>>: 12/17/09, Embassy Suites, Baton Rouge, 9:00-3:00
>>: Long Term Care Systems Transformation Stakeholder Meeting.
ROGER AUERBACH: Good morning everyone. We will start in about 3 minutes so get drinks or any nourishment you would like. We will get started in about 3. Thanks.
TAMMY LEBLANC: Good morning everyone. I just want to welcome you today to the semi annual Louisiana systems transformation grant stakeholders' meeting. We are expecting other folks. They may be traveling from further away. But we do want to get started because we have a lot to cover today. This morning we will have updates from our assistant secretaries of the office for citizens with developmental disabilities, the Office of Aging and Adult Services, and the Office of Mental Health. Directly after that or somewhere in there we will have a short break. Then I will give an update on the entire, all of the activities going on with the grant. But with the focus on sustainability. As we go into our last 9 months of the grant we want to make sure that all of this incredible work that so many people have been a part of becomes

a part of our operational procedures and policies within the state, within the program. So we'll be talking a lot about sustainability. I will be stopping after each part for questions and input, talking about sustainability is a great place for people to let us know how and where and what they think we can do in terms of making sure that this lives beyond the grant period. I would like to go ahead and get started now with Kathy Kliebert, assistant secretary, office for citizens with developmental disabilities.

KATHY KLIEBERT: Good morning. I am going to give you a couple things I think are significant that we have been working on and give you some ideas of things we are moving on in the future. I will start out talking about sustainability of this grant. For most of us because of where we are with our budgets and what budgets are looking like for this fiscal year and next and the one after that, we are really focusing on our sustainability of our services and being able to assure that not only that people that are currently getting services will continue to get those services but also that we can continue to offer services to people who need them. Really, really tough task, and very hard to balance in our current economic situation, both for the state and for the nation. But in

particular this fiscal year, we have already had provider rate cuts. We have had some previously in this year we had freezing of waiver slots and other things that were necessary in order for us to be able to meet our budget. So we have been asked and we have been working on this. This is really part of the transformation grant as well, trying to make sure that we have a system that is sustainable for the future. How we do that, we have been working on numerous front. Many like I said are initiatives that are part of this grant. We have worked really hard to assure that we can keep giving services to people and to assure that the quality of services that they're getting remains like we want it and that people are truly not only getting the services but the quality of their services meets our vision and our principles and our values. Again, a really hard balance in these economic times. What we have done is every time we have had to look at budget situations or fiscal decisions, I always go back to our vision, our office vision which is building relationships and supporting choices, as well as our longterm care vision. Many of you may have been part of the development of the longterm care vision for the state. We developed a vision for those who are aging and adult-onset disabilities. We developed a

vision for developmental disabilities. That vision was to empower people with developmental disabilities to have the opportunity to make choices in their lives and live their lives with dignity. Again, every time we had to look at our budget issues and as we continue to do this, we try and look at that vision when we make our changes. That being said, when we looked at having to make some significant changes both this year and next year in our service delivery system, we looked at that vision. How do we do that? How do we make sure people still have that opportunity to be empowered and to make decisions in their lives and to live their lives with dignity? By focusing on that vision, we came up with a couple strategies. One was a strategy that we have been working on for a number of years. That's fairly allocating resources according to needs, that based on the person's support needs that they would get what they need, no more, but they would get what they need. We also focus on increasing person centered planning and giving people choices and how they use the resources they have and that those choices match what the person wants in their life. It is, again, that balance of giving people just what they need and looking at what's important in their lives and making sure our services can

be a balance between the two, between what somebody needs and what's important in somebody's life. We also had to look at restructuring of supports and services centers. We are a highly institutionalized state. We all know this, have always been. We cannot sustain our services and that vision in the future if we don't make some substantial changes to our supports and services systems structure. We have looked at this in the past year, made some changes. But we'll be proposing some very significant changes over the next year in order for us to, again, sustain this system for the future. We also look at resource allocation. Getting to that, making sure people's needs match the resources that we have available. We implemented July 1st our resource allocation system, our planning, our new planning guidelines which had a whole bunch of not only new person centered principles in it but new guidelines for individuals to plan for individual's lives that were based on what we knew about the person and what was important to the person. We also enacted using our supports intensity scale assessment. It is a very standardized assessment used in 17 states that allows you to really look at the strengths of a person and at the same time determine their level of support needs. We

have used that to allocate a level system where people are allocated a level. Based on that level they will be given a certain amount of supports. We have developed this system so it was very flexible, where we had opportunity to, number 1, assure that this resource allocation would not institutionalize people. We do not under any circumstances want people not to be able to get the supports they needed to continue to live in the community. Also, that it was a system that would allow us, based on again the individual's needs, to be flexible about the hours. Even though the resource allocation gives you a certain amount of hours, we can be very flexible within that system in terms of adding hours if we need to. We implemented this system July 1st. We have had a little over 350 people that have currently gone through this new resource allocation model. Out of the 350 people, we have had about 82 that have requested additional review, meaning that they felt they needed more hours than what they were allocated based on the supports intensity scale. Out of the 82 people, we have been able to resolve all of those issues internally. We have had no formal appeals of our resource allocation model. Really excited about this, because that was one of our big concerns, that we

would get a lot of appeals as people started to be asked to look at their number of hours differently. We believe that has to do with again the flexibility of the process and also that it is so person centered and based on new planning guidelines. We invested enormous amounts of training in the process and feel that because of that we have been able to implement successfully some of those changes in people's hours. The other really exciting thing is out of the 350 people, we know almost every single one will have significant reductions in their plan cost from last year's plan cost. Not all. Some will have actually some increases, again, because the system for people before for people that weren't getting what they need will get what they need. Those that were getting more than they need, those hours have been reduced. Again, we are not jeopardizing any health and safety nor are we jeopardizing their ability to live in the community. I don't have all the final statistics yet in terms of the numbers or the amount of savings but our estimates now just for the 350 people are somewhere around $3 million. Again, significant for that small amount of people when we have 8,000 new opportunity waiver slots. Multiply that and you will get very significant savings. At this point until we know for

sure what the data looks like, we are not making the estimate that we will get 3 million for every 350 people. But I am letting you know we have had very significant reductions in plan costs. Again, all that have indicated that the people's needs can still be met successfully in the community and no jeopardy to their health and safety. And in many cases with increasing in independence and much better plans in terms of being focused on what the person wants in their lives. We are real excited about that. It's another portion of what we are trying to do to balance to make our program sustainable. Other things that have been going on. The money follows the person. You will hear about that later on today. We did have a residential opportunity waiver approved as of October 1st. So we now have a vehicle to actually move people from facilities into waiver opportunities. So with that vehicle which hopefully will be implemented some time in February. We are working on getting the final rule out. We had a rule out. But we are going to request that we make changes and get it out as emergency rule hopefully in the next month. We will be able to offer people who are leaving institutions with the residential options waiver some opportunities to live in waiver services. The only

problem we had is when we first developed the waiver we actually had funding and had 200 available slots funded by the legislature. Since then, that funding has gone away. So the opportunities we have right now are opportunities to convert current ICF into the residential opportunity waiver. For this fiscal year, that's what we will be working on. We will also be working on people who may choose a residential opportunity waiver instead of the NOW. Our rule will allow people to choose a residential opportunity waiver instead of a NOW which will be cost effective. For some people some of the options like post home option and companion option that we don't have in our NOW, they could use that in the residential opportunity waiver. They'll have some of those additional options available to them that they don't currently have. We are hoping that next year we'll have some increased funding opportunities to use that residential opportunity options waiver a little bit more fully than we will be able to do this fiscal year. Since it took us almost 3 years to get this through, we are very excited that we at least have the option now on the table. So when we go back to the legislature to say it's there, we can use it, it's a vehicle that we can use if we can get additional funding. So,

again, that gives us one other tool in terms of us being able to restructure our system. I mentioned before that part of our balance was trying to do all this, make sure we are matching needs to resources and that we are using our money as wisely as we can, that we are moving people from institutions, that we are reevoking supports and services centers all at the same time assuring quality. Some of the initiatives that have been part of the transformation grant which are developing our quality indicators, developing new systems for monitoring for support coordination, as well as some other overall quality initiatives that we are developing as part of the transformation grant, we have in process. We are again not there yet. Again, you will hear about some of these later today. But we are moving in terms of changing on expectations of providers, changing expectations of support coordinators and being able to look for the input from providers and support coordinators to see they are doing what person centered plan says, what people want in their lives and assuring health and safety in all of that. The indicators that were developed as part of the transformation grant, we are using now, but we hope in the future it will be able to be a really good gauge of how we are doing in this system,

being able to tell us system wide are people really reaching the outcomes that they tell us are important to them, as well as outcomes that we determine are important as stakeholders. Health and safety initiatives and other things like that. Once we can use that system wide, we will have a much better indicator of how we are doing. We have the national core indicators that we have used. This is our second year of gathering data for that. That is another initiative that will really help us in terms of gauging our quality, determining strengths and weaknesses as a system, and being able to identify our weaknesses. We use national core indicators this last year to help us develop quality improvement projects. So we have those tools in place. Again, some of them have been clearly a result of this transformation grant that we can use to help us assess the system and improve the system for the future. Our struggle for the next 6 months for sure is going to be how do we keep all these things in place, keep everything going at the same time that we meet the budget reductions that we are all going to be faced with? We constantly turn to our vision when we are trying to balance these things. We constantly turn and say if we make the reduction here, is this something that is truly going to help us get where

we want to get to as a system down the road? For me, especially it's the best way I know to be able to handle these budget reductions. As tough as some of these are right now and are going to be for the future, I always look at it and say but it's going to get us where we need to be able to sustain our waivers, community based services and our quality services in the future. That's I guess updates as to what we have been working on and what we will be facing in the future. Questions? I have never come here and not gotten questions.

ROGER AUERBACH: Going once. Okay. I am surprised. It was a very comprehensive discussion. The challenges that you are facing with budget reductions and keeping your eye on objectives and goals that you have is very, very difficult. I want to personally congratulate you because as I go around the country and work with states, sometimes the budget problems are so intense that people can't do anything other than hunker down and sort of say what am I going to do today? So keeping your eye on the prize and where you have been, where you are going. Congratulations.

KATHY KLIEBERT: That's the only way we know how to get through it, to keep every decision we make that

hopefully will be the decision that will help us get down the road.

ROGER AUERBACH: Last call, last call. Okay. Kathy thanks again.

KATHY KLIEBERT: And I have to leave. So thank y'all.

TAMMY LEBLANC: Next we would like to welcome Mr. Eley. He is assistant secretary, Office of Aging and Adult Services. While he is talking, think of some questions for him. Really good questions. Or answers.

HUGH ELEY: I think we are all not awake yet in this dreary weather. Everybody quieted down. Good morning. A lot of what I would say really echos what Kathy said. I think obviously the thing that's foremost on everybody's mind which Roger put it well, it's difficult not to day to day when you are bludgeoned with the bad news and trying to get through this exercise and that exercise. What if this and what if that? It will be tough. Kathy says 6 months. I think realistically it will probably be 18 months. The good news is that it's still all subject to change and will continue to change as we go forward depending what happens in Washington, what happens in Baton Rouge with the recession. I think especially when you talk about our population we serve, even more so than the DD population, is sustainability is

absolutely critical. The elderly population is the fastest growing population in the United States, and there is no end in sight. For many, many years the OCDD waiting list for waiver services was 9 or 10,000 people and ours was 2 or 3,000. I don't know what yours is now. Ours is 18 thousand people on the EDA waiver waiting list. We are adding almost 1000 people every month. The challenge becomes going from a period of time where we have seen tremendous growth in the amount of resources that we are putting into community based services from just a few million dollars a year to now over 300 million a year we are spending on community based services for this population. It's not going to grow for the next few years. The issue really becomes how do you take that money and use it more wisely to try to serve the demand that's not going to stop? That's a challenge. I forget some famous exlegislator that said the hardest dollar to take away from somebody is the dollar you just gave them. We are going through a very painful process over the last several months. Kathy talked about their resource allocation. We started ours in March. It's very similar methodology. We could not afford to sort of phase it in. I think I have talked before that our EDA has been out of compliance with the feds

in terms of it not being cost effective with respect to nursing homes. We didn't have choice about phasing in. We had to go in and make reductions in people's services. We have had lots of appeals. I think the good news is that we have not seen today any increase in people having to be institutionalized, in people having to be discharged from the waiver for health and safety reasons. So despite the reductions, people are finding ways to make it work. I think quality is a big issue. I would echo what Kathy said. The systems I think have been put in place are very positive. We are starting to see some results. I will talk about how we are putting some of the results into play. I think getting people the appropriate level of services. There is the idea that there is some magic number out there. I don't know what the magic number is. I think as Kathy said it is key that you have good assessment process, that you have a good planning process, that you are giving people services they need, but not anymore services because there are 18 thousand people waiting in line to get there. So every dollar you spend on anybody unnecessarily is a dollar that's not helping those 18 thousand people get off the waiting list. It's a tough process. Families have a stake in it, consumers have a stake in it, providers have

a stake in it. It's a real balancing act to try to make that work and convince people that we will do our best to give you what you need with the constraints that we have. I want to say a little bit about another focus that I think we have to make in this day and time. That is accountability. There are things going on in the department now, trying to make sure that the services we are paying for, that people are getting the services. Again, money wasted. I don't want to say it's fraud but just bad documentation or whatever. If you are spending money you don't need to be spending and you have that kind of demand, that's something you can't afford to do. We are looking at trying to get more accountable being sure that the money we are spending on for services are providing services we are supposed to provide. Another big issue going forward is we have to give people more choices. For years we had no community based alternatives. Now we have community based alternatives but they're really very limited in what we provide for the elderly population and population for individuals with disabilities. It was basically personal care and services. One of the things we have learned from quality data we have done and consumer surveys is that not what people need or what

people want. We did our first survey last year on the EDA waiver and one of the most frequent responses we got from people was that if they had certain kinds of devices, they would be better off. They wouldn't need as much personal care. They wouldn't need as much having somebody come into their home and help them if they had those kinds of things. That and other findings like that have helped to inform what is really the most exciting thing I think we are doing now that I want to talk about a little bit. We have been for over a year now working with stakeholders. Some of you in the room to essentially reinvent our entire service delivery system. We are working on a new waiver that we hope to submit to CMS early in the next year that will ultimately replace the service system that we have now in whole or in part, that will have a much more comprehensive set of services. It will still be subject to the same sort of individual limitations in budgets based on your assessment, what we are doing now. But we really believe based on the feedback we have gotten from stakeholders, feedback we have gotten from consumers, while we recognize that personal care assistants is still always going to be the number 1 thing people need and people want, that by giving people

more options and more choices that you can actually meet individual people's needs in a more person centered way, and you can probably do it at a lower cost. You can help to move and shift the dollars around and serve more people. We have been working for years -- I am tired of talking about it actually -- our system living waiver which we hope will get approved early next year. I think that's terribly important not only because it provides another option for people who maybe can't have their needs met -- but it provides an opportunity to convert a lot of unused nursing home capacity into something useful in assisted living. Other kinds of services. I talked about assistive technology. There was a presentation a guy did at the legislature a couple weeks ago about a system that can dispense medication, can monitor somebody's movements inside the house, if somebody falls they immediately know, an alarm goes off. If somebody just deviates from their normal routine an alarm goes off. It's not cameras or privacy invasion. It's motion detectors and things that are timed and programmed to dispense your medication at the time you are supposed to take it and all these kinds of things. Wonderful technology is being used in other states in community programs. The cost of this

stuff is peanuts compared to the cost of what we are paying now. We are paying somebody to go and be in the home in case something happens. We talk about sustainability. That's not something we can continue to do. For $150 a month you can provide the same level of assurance for somebody's health and safety needs. For another $150 a month, you can have a machine where they can get their blood pressure checked and do all this stuff electronically, which we don't do at all in our systems now. As opposed to $150 a day you are spending to have somebody come there and sit in the house and essentially do nothing except be there in case something goes wrong. That's the kind of thing I think gives us potential to meet people's needs but do it more efficiently and cost effectively and be able to get more people services and not leave so many people with nothing. Other kinds of things we are talking about doing in this new waiver. The services that we have now, personal care and things like that, will continue to be provided. More services that can help people improve. One of the things we found through consumer survey, in looking at quality, looking at assessment data. A large number of people we serve that have potential based on assessment to actually get better. Oh, older

people will always decline. Not always the case. We don't have a service we pay for that helps them do that. So we will put rehab services into this waiver. If a certify son scores on their assessment, with a little rehab, this person can become more independent rather than growing increasingly dependent on the worker, we'll be able to pay for those kinds of things. Home delivered meals and other services like that provided through the aging network, through councils on aging, that's a more cost effective way to provide for somebody's nutritional needs than to have to pay a worker to go to their house and cook lunch for them. Transportation. Another thing we found from surveys is even with Medicaid and transportation and all those things out there, it is still difficult for people to get where they need to go. We can pay for that kind of service. I forget. There is a whole list of about 15 things we have come up with. It is a much more expansive list. I think at the end of the day what you will be able to do is really tailor a plan of care specifically to a person's individual situation that helps them get better, that helps them get health and safety needs met and do it in a more cost effective way than to argue over how many hours you will have somebody come to your house. An expansion of daycare.

Daycares and other services that will be available. We are really excited about that. We hope to have it approved in time to have it start up in July of next year. I think it will be a real change. Briefly, other things. Money follows the person. We are going forward with that. Particularly we focused in the New Orleans area in conjunction with our department of supportive housing program. Our office does local supportive housing in New Orleans area. We have had people successfully move out of nursing homes. We have a lot of people that have a much greater level of interest than we thought we might on that. We are pushing forward on that. We are excited about being able to help people get back into the community. We are -- you have been moving around the state, you are probably aware of the streamlining. Some of the things that have come about through that that are probably going to come about is the Department of Social Services is sort of focusing their attention more on children and families. There are some adult programs they're devesting themselves of. Some will come to us. There are programs with PCAs for people with disabilities. Those will move to our office. There is traumatic brain and spinal cord injury program, a trust fund is set up that's also going to be

moved to our office. We are hopeful based on some preliminary looking we have done that there is some synergy there between those programs and Medicaid programs we run, that there is some overlap of who is being served and we'll be able to maybe coordinate that more closely and spread the funds a little farther by making sure that we are using the best payment source to pay for whoever and also possibly by leveraging some of those -- particularly trust fund funds to get some waiver services to people with brain injuries and spinal cord injuries and things like that. Another thing I want to mention about the waiver is we are looking at being able to do different levels of service within the waiver so people that really have high needs who are now what helps the waiver not be cost effective, we have a different standard we can use so we can deliver more intensive services to those people who really need them. Another thing that's come about in streamlining is a little bit of talk about piloting some sort of managed longterm care system. Some of you have heard us talk about the PACE program which is such a system. I think there is interest in looking at other models where you bundle services and a provider would get a bundle rate to provide a full range of services to the person in

the community or if necessary in a facility. We'll probably be working on that in the next year or so. I want to say one last thing because I think when we come to the meetings and we talk a lot about community based services and we all believe in community based services and we all want to improve community based services, I think sometimes we forget that there are always going to be facilities and there will always be people that need that level of care. There will always be people that have to have that level of care. I think it is important in talking about systems transformation that we talk about how do we transform those institutions or facilities. We have a couple nursing homes in the state and hopefully more that have been working with our office and health standards on moving into what they call the small house model which is away from this big 150 bed facility and into sort of a campus arrangement with small homes with 8, 10, 12 people in a home. There is differences in the staffing. They have staff that are there 24/7 and do all the things so that staff and residents really develop the same rapport you do with a worker coming into your home. In the community I think that's a wave of the future and I am happy to say that we do have some operators in our state that are

beginning to look to that. We are trying to do everything we can to make sure there aren't regulatory barriers or anything like that that stand in the way of being able do that. We hope to see when we talk about facility based care, the day will come when facility and institution are not synonomous terms. I will stop there. If y'all have had enough coffee and some questions come to mind I will try to answer them.

ROGER AUERBACH: Questions? Mary.

AUDIENCE: I would be interested in what sections of the state those nursing homes are. Are they in metropolitan or rural areas?

HUGH ELEY: One is in the central part of the state. I don't know for sure if it's located like in Alexandria. I think it is in one of the smaller towns around the Alexandria area. The other one is in New Orleans.

TAMMY LEBLANC: Asking a question for someone else at my table. She's interested in all the services you talked about on the new waiver. She wanted to know once it becomes approved, how will you let the public or even other organizations know about all the different services and what will be happening on that in that new waiver?

HUGH ELEY: Well, two things. We did invite at the last

stakeholder meeting we had, we did invite some providers or associations of providers who would be new providers who might be involved in that. We didn't have a lot of interest because I don't think they really understood what it was at this point. If we get the new waiver approved, obviously it will be a big deal and there will be an announcement and probably a press event and the whole 9 yards. Word will go out to the provider community, both current providers and new providers, that this is not something that's available. Support coordinators will have to be really trained because this will be a big change for them. Now when you start to write your plan, you have this whole array of options. You don't just have 2 or 3 things. Then eventually over time, what would happen is as people come up for renewals in the current waivers, they transition over into the new waiver.

TAMMY LEBLANC: I think she mostly wanted to know what was on that list.

HUGH ELEY: I can't rattle it off. I will be happy to get it to you. Julie, maybe you can help me. We have medical services, therapy, rehab, nursing services, home delivery meals, transportation. Any technology. It is not just an assistive device. It helps you move but it is

other things that we talked about earlier. Monitoring system and all that stuff. Can you think of anything else? Things we have now. Personal care, adult day healthcare and all these kinds of things.
HUGH ELEY: I may be missing one or two but I think that's most of it.
ROGER AUERBACH: Further questions for Hugh?
TAMMY LEBLANC: Quiet bunch.
ROGER AUERBACH: They're waiting for Patricia.
ROGER AUERBACH: Thank you very much. Pretty exciting even in these tough budget times.
TAMMY LEBLANC: Thank you. That was quite comprehensive. I am sure everybody here appreciates that. Next on the updates is Tricia Hensarling with the Office of Mental Health. I was afraid of that, Trish, that you were going to get all of the questions. Let's hear from her. I know she will be well prepared for any questions you might have.
TRICIA HENSARLING: I can always get back with you if I can't answer you today. I am happy to represent Jennifer Kopke, assistant secretary for the Office of Mental Health. As everyone said we have been fast and furious in different meetings for the last several weeks about the big B word, the budget. Our leadership right

now in the Office of Mental Health is very much focused on the principles of servant leadership. So we are looking assertively at how to be very good stewards of the state monies that we do receive into our programs, any of the federal funding that we receive. When I say that about good steward, we made a modification within our system of care with our contracted services that we held and scrutinized every contract that came in from across our system from the different regions. We put in an extra help to look at those outcomes, to look at what our expectations were and if the outcomes were being met in the previous years. If not, we would tighten up those contracts. If you hear in the news about any slowness of contract negotiation, it does stem from the fact that we have tightened that up quite a bit and we are looking very aggressively at the outcomes that we want to see that provide quality and good services and that the services that the contracts were for are being delivered. We are also charged by Jennifer to look at these contracts on a monthly and definitely on a quarterly basis to see if we still are maintaining outcomes and performances. If not, then we go back in to renegotiate and discuss at what level expectations are and what we need to do to get back on the path of

delivering services. Within the Office of Mental Health, I spoke previously to this group about moving from a regional level, state run regional system of care to a local governing entity system of care. On that note, the Office of Mental Health is now really down to 6 regions in the state. That would be our system of regions 3 which would be the Houma area, region 4, Lafayette, region 5, Lake Charles. 6, Alexandria. 7, Shreveport and northwest area. In the northeast section would be region 8 which is Monroe. Right now our legislation allows for readiness criteria and some outcomes of along the way in order for you to meet the 4 criteria of readiness before you become a local governing entity. Being a local governing entity allows that OMH system director to have more control over their dollars and their funding. It will still allow the state level office to be somewhat held accountable the dollars, state general funds that are going into the local governing entities. I will just say that we have region 3, the Houma area that will be going to a local governing agency. It will be coming out from under the Office of Mental Health July 1, 2010. We have region 5 which is Lake Charles that will be submitting their letter or application for readiness some time in February 2010, and they will start working

their readiness process which will is about a year to 18 months. The next region we expect, region 4 also has submitted their area which is Lafayette. I expect Lafayette and Lake Charles to move in 2010 or 2011. Then we are working assertively with 6, 7, 8, Alexandria, Monroe and Shreveport areas and surrounding parishes to go next. As far as where we are with our own system with the 6 regions, we are looking at utilization management. We are accessing a service through David Lloyd who is helping us with our quality assurance improvement and our outcome based data driven decision making. On that note, with utilization management, we are asking our teams and our staff in the regions who are delivering mental health services to consumers or clients to be reviewed as far as their credentials. Their capability of providing the right service to the right person. Their training to be person centered on their treatment plans. The credentialing process has been moving forward and continues to move forward so we match those services and those providers to those services. Also we are looking at the issue of access to our services in a timely manner, especially our community services. We are in an initiative now to move the access window down to 7 to

10 days which is pretty phenomenal because we have had some issues and challenges across the state with getting individuals into services. So we are restructuring our systems in order to be able to open up that access for assessment. Also we are using an instrument called the locus. It is a level of care utilization system. It is a very nationally known system of scoring an individual on many different dimensions and matching up the needs for that individual. So you can receive a score from -- a level from 0 to 6. We are looking at what service packages need to be delivered in those different levels of care and being able to be flexible as you move from one level of care to another. We will start at whatever we have as the highest level of care. Our person centered focus will be if you are a level 5, to start working assertively with you on the issues in order to drop your level to a 4 or 3 or 2. That will be your service delivery requirements that would drop as well. That is the most efficient and effective way to use our dollars that we have to provide the services that are needed to be individuals receiving those services. Also I wanted to tell you that we have a huge initiative with discharge from our institutions. We are working very aggressively with our Olmstead project. We are using individuals out

of our intermediate care hospitals. We have 3 intermediate care hospitals. I will share with you that I personally met a gentleman that we have discharged from the east Louisiana state hospital who is now living in community based services. He was in our hospital for 17 years. And he is doing beautifully in the community. He is one of our leaders in one of the residential placement that we have him. We will also be applying for permanent supportive housing for a lot of our individuals coming out of our institutions. That's a huge initiative. We are getting lots of referrals. We are going into the hospital setting and providing assistance and helping to get individuals moved out. I do want to say publicly thank you to Kathy Kliebert's department and her division and staff. We have been able to cross reference our databases in order to be able to identify individuals in our intermediate care hospitals that also have eligibility for services with OCDD. As those individuals come out of our hospitals, then they have those services that are in place as soon as they walk out. That's been a great, great opportunity. That's just another way of collaboration among our different departments. We are also working on what I called planned discharge planning with our institutions so we

have as many benefits in place when that individual leaves the campus. We are working to reinstate all financial benefits. Social security, SSI, any financial benefit. We are working assertively to reinstate Medicaid/Medicare so individuals can have access to programs, partial hospitalization or mental health rehab medical services when they leave our campuses. We are also looking to get source documents for these individuals so when they leave our campus, they have the necessary documents such as birth certificate, social security card, ID so they can be able to sign up for any services, especially our permanent supportive housing initiative. So they will be on those waiting lists. They can be moved into the system of care and get that service as it opens up to that population. We are starting conversations with the office of public health and vital statistics division to see how we can collaborate on accessing birth certificates, because that is a funding issue. But I am committed to put some money into that to be able to get the packets out when individuals leave the campuses that we have been charged to serve. Let's see what else. We have been very good stewards with the charge that came to us about individuals that are in our hospitals that are

termed lock hearts. There is legislation that says that anybody that couldn't be restored to competency for whatever crime they committed -- for example if they had gone to jail they would be released and out for time served. If they have come into our institution they have somehow gotten lost. So the legislation charges us to release the lock hearts and get them back into the community. We are working hard to do that. Let me tell you that part of the process requires that you work with the legal system because you do have to go before the courts. You have to say this person has spent this much time and they're doing well. We recognize that it's time for this person to move to the least restrictive environment in the community. That's all a collaboration. We have a lot of people working on that. Let's see what else I have for you. Oh, we have worked really hard to build a crisis system. We have worked with many different stakeholders in all our regions. Our L G E's did it as well. We have legislation to create a crisis response system. So that is pretty much being affected right now as far as when the crisis is out in the community, a rural community, who is the first line of contact, how do we recognize that this person has special needs or are in a system of care that we need to

respond to in a little bit of a different manner than our traditional manner. On that note, we also have in our communities, crisis intervention teams. The police have been trained to work with this population, our population, so they have better skills instead of going in and they recognize medications and about symptomology so we are not arresting and trauma advertising our mental health clients but we are treating them with respect and dignity and helping them to get served in the right setting instead of a punitive setting. On that note, I assume I am going to have questions.

ROGER AUERBACH: Hope so. Okay. Ron, I will be back there.

AUDIENCE: You didn't mention the word veterans. Do you tie in with the veterans? What about people that come back a little crazy? You must have some of that. Right?

TRICIA HENSARLING: We do serve veterans. We have been charged through our federal block grant to make that a particular population we serve. We work with presenting to the veteran any other services, packages that we can collaborate with. Veterans are accepted into our system of care. We have that population served, yes, sir. Thank you for that question.

There is a huge need there.

TAMMY LEBLANC: When you were talking about Houma and then Lafayette, I didn't understand what you meant by that structure, that they were going to be separate from OMH.

TRICIA HENSARLING: They're becoming local governing entities. Like they don't report -- we don't have any governance over. The Office of Mental Health doesn't govern. We collaborate with those local governing agencies. For example, region 1 in New Orleans used to be under the Office of Mental Health. It rolled out into a local governing entity called metropolitan human service district. Florida parish human service district used to be region 9, I believe. Now they have their own local governing entity. So we don't have direct oversight. That's what Jennifer Kopke has been charged with when she first came on board as assistant secretary, to move regions into local governing agencies. You have legislation that identifies the structure and the boards and the executive directors who are over these local governing entities report to their boards and decisions are made in that format for funding and for distribution and service needs of that nature. So, yeah, that is what I meant when I say region

3 is Houma. They will go to south central Louisiana human service authority or something like that. A mouth full. The next one that will probably roll will be Lafayette and then Lake Charles.

ROGER AUERBACH: Another question in the back.

AUDIENCE: As we move to more human service districts in the state in terms of the budget of the Office of Mental Health which will eventually become the office of behavioral health, will the human service district's budget be tied to your budgets or those separate budgets in the state?

TRICIA HENSARLING: I don't know how to directly answer that question to be real honest with you. I know that come 2010, July 1, that instead of having -- in the Office of Mental Health instead of having 3 area budgets, 3 budgets across the state tied to 3 different hospitals, it will be one budget coming out of the office of behavioral health. I think you are reminding me I should have said that. O A D, office of addictive disorders and Office of Mental Health will be office of behavioral health come July 1, 2010. Their funding comes legislatively to the district. So I don't really know the exact line of how that funding goes. I can't answer that at my level, but I will be glad to get that answer for

you.

ROGER AUERBACH: Thanks Tricia. Further questions?

AUDIENCE: Elderly and depression? Any services.

TRICIA HENSARLING: That is very near and dear to my heart, the elderly. As part of our block grant initiative, I wrote in with management's backing that we would look at the older adults for mental health and physical health needs. We have that initiative right now out into our regions of trying to be sure we identify that population, that special subset of a population. And we look at how we are medically challenged to meet the needs of that population. So, yes, it is a huge part of what our division is looking at.

ROGER AUERBACH: Tricia, you were right. You have a few questions. Mary.

AUDIENCE: My name is Mary Francis. I am heavily involved with AARP. I know that you have a system or you have stakeholders that have quarterly meetings. I work with the representative from AARP, John Poland on that program. We want to raise the whole issue of not only elderly depression but also the whole thing of substance abuse. I think this is an area particularly, there is a lot of research with elderly males who are

either divorced or single or widowed. They tend to not have the support of their spouse. So there is a lot of hidden issues. We continue to press for that.

TRICIA HENSARLING: I strongly appreciate that. Now, I do recognize in meetings that I have seen you have been a part of. You are right. When we talk about depression, our state medical director, Dr. Dalton and I have had many conversations about the subset within our population that we serve. We are looking at the senior adults with depression, with the support system, what you are talking about, trying to be more focused on their medical and their mental health and whoever is their primary care that there is some collaboration there so we can identify the special needs, and the issues with depression. We also know suicide rates and things of that nature. That's a national issue. It's also one that's near and dear to our hearts. Even though we have in our system of care -- here is our criteria to access our system. We have caveats of okay here is a subset that we are also going to identify. I can tell you another one that's dear to our heart for our state medical director and our team as well, it is the depressed mothers with small children and the impact of raising children with a depressed parent. We are working on

the front end to try to look at it. We are looking at trying to move people through the system. Your life is not defined by the office of behavioral health that's coming. So you are not your diagnosis. You are more than that. So we really accept the principles of recovery and that you can live a quality life in the community of your choice, in the environment of your choice. That's really where we are moving. Those two subsets, the veterans and elderly with depression, that is on our radar screen. Thank you.

ROGER AUERBACH: Further questions for Tricia?

AUDIENCE: If we wanted to get a training at our agencies or say at aging disability resource centers on what services you offer, do we do that regionally or should we go through your office?

TRICIA HENSARLING: We have within our office workforce development. So you would contact that division. That's Dr. Joseph Comade. You can get with me and I can connect you. Any training needs can come through that office. You can do it locally but I would encourage you to go to Dr. Comade and his team who would set that up. If you are needing it, they would try to take that around the state as well so others would benefit.

AUDIENCE: Thank you very much.
TRICIA HENSARLING: You're welcome.
ROGER AUERBACH: Tricia, I think you have done it. Thank you very much.
TRICIA HENSARLING: Thank you.
TAMMY LEBLANC: I did want to recognize that we have Ray Dawson with Medicaid with us. I think he was hoping I wouldn't do that. But he is here and glad to have him.
AUDIENCE: With respect to the question about the budget, maybe you can add this, but the district budgets are of their own making. They're part of DHH but they get their own budgets. Somebody asked a question about when they go to the district area. They'll have their own budget and it will go to the legislature and be appropriated like any other entity.
TAMMY LEBLANC: The purpose of that just with the ones I know is so they can be more accountable in the region to the services or how they design it. That's my understanding. We are going to have a little break. But I want to comment on how struck I am, especially at this meeting, how incredibly far the different programs have come since this process began. In terms of switching to real outcome performance based measures, in terms of

how person centered and individualized they are, while at the same time looking at resources and all the citizens with disabilities or the elderly that they need to serve. While I truly believe that the systems transformation grant, especially the stakeholders that have given this type of input, was really the catalyst for it. I really must say that I think what you are seeing in terms of the results is due to the incredible visionary leadership of those programs and just the intensity and tirelessness in which they have kept that vision in mind and continue to work for it. So even though I work on the ground on a day to day basis, I have to come to these meetings to really see from time to time just how much progress is really being made. I really do believe that it is the leadership and the staff who carry it out. So if you have thought of any questions, we will let you ask them. But if not, we'll have a 15 minute break and we'll come back. And I will give you some updates on the grant itself and the activities.

ROGER AUERBACH: Seeing no questions, it's time for a break. We will get started in a couple minutes so if people want to get drinks or anything, we will get started in a couple minutes. Thanks.

TAMMY LEBLANC: I will start with a few housekeeping

issues that have come up over the break. Several of you have been asking about the transcripts. By the way, even though -- I am sorry, I don't know your names. I do want to recognize what an incredible job our transcriptionist has done at all our meetings. She has had several compliments already. Stephanie. The name of the agency is Computer-Aided Interpretation. They have done a fantastic job for us and we really appreciate it. All of their transcriptases are on our DHH website. It's under OAAS Louisiana systems transformation grant. It's a long E-mail address. I do have it on the slide presentation that's in your packet. The website is on the last screen along with my name. So you can go directly there. The other piece is that Mr. Eley asked me to give you kind of an update or clarification on the new waiver that he was talking about. Unfortunately, there will be no new money so it won't create new slots right away. But as people get the exact services that they need or the exact technology, we are trying to go toward a system where the savings can eventually open up new slots. So I know maybe for a lot of you -- it is exciting because people will get better quality services more specific to their needs. But at the beginning it won't open up any new slots. That's kind of

the bad news. The good news is that Mr. Eley has opened the contest for naming the new waiver. Truly, if you want to submit a name for the new waiver, it will go to Sandra Guthre at our offices. Jeanie would you know? Is it sandra.guthans. Let me start off. Sandra.guthans@la.gov. Do I need to repeat it? You would be surprised when you are standing up here what it does to your brain. Anyway, it truly is. There is a contest to name it. What I have heard through the grapevine is they want it to have some character and really kind of be warmer but not too cutesy. Kind of stay within that framework.

AUDIENCE: What's the prize if you win?

TAMMY LEBLANC: That becomes the name of the waiver. It seems like there was one more thing I needed to mention. Donna, what time will lunch be here? Lunch will be here at 11:45. We are running ahead of schedule. I have never said that before.

ROGER AUERBACH: Is anything wrong?

TAMMY LEBLANC: No. We'll go home early. We'll cover what which need to cover and we'll go home early. Now what I want to begin on is the grant itself. I have a PowerPoint which you have in your packets. I will do this slowly. As I go, I am going to introduce other

people that are working on that activity. Then once we explain it, we'll see if there are any questions. It will be kind of an interactive kind of exercise. Before I start though, I want to get a general sense of the audience. So I am going to ask some questions. I want you to raise your hand if you belong to that group. You can raise your hand more than once. I understand that you may be doing more than one thing. If you serve people who are elderly, raise your hand. Wow, great. If you serve people with disabilities that happened after the age of 22, raise your hand. If you serve the developmental disabilities population, raise your hand. Do we have any community based, home and community based service providers here? Any support coordinators? Thank you. Just wanted to get a sense of the audience. There are a lot of new faces today. It is wonderful, great to have you here. We will see if I can do two things at one time which is press the button and also talk. I don't like my back being to people so let me try this. The whole reason that I have the slide here is because I like this picture. It reminded me of the inequities in the state on what percentage of funding was going to institutions and institution like facilities and what was going to community based. Let me reiterate

with Mr. Eley that there will always be a place for skilled nursing or facilities for people with very high needs. So as I go forward, I'm not targeting that. But we know that in Louisiana and around the nation that there were many, many, many people, consumers of services that were saying we really want to be out in the community. We are quite capable of leading a full life, whatever a full quality life meant to that person. So there was a movement 20 or more years ago to see what types of supports people needed to live in the community. We are at a time that we now have that information. So it really began time to rebalance the state's longterm care system to provide greater access to noninstitutional types of settings which is the community based. That's why I like this little picture. We had 3 goals on the grant. Let me give you the overview of that. The first was quality. The second was information technology. The third was housing. We'll begin with the quality part. These were the targeted outcomes. To develop and implement a comprehensive quality management system, develop and disseminate Q M data and reports to stakeholders, and periodically reevaluate Q M strategy. What I would like to do now is all the people here that work on any of the quality workgroups, I would

like them to stand so I can name them for you. Dena Vogel with the Office of Citizens with Developmental Disabilities, Beth Jordan with the Office of Citizens with Developmental Disabilities, Julie Nesbit with LATAN, Jeanie Level with the Office of Aging and Adult Services, Mandy Jones, Office of Aging and Adult Services and Alison Vuljoin Office of Aging and Adult Services. If I get to a part I may ask one of those to explain it further. After we finish the quality, we'll all be available to answer questions. I notice that Mary Francis didn't stand although she is on quality workgroup, the leadership quality which is our stakeholder group specifically for quality. These were our -- I was going go into sustainability but I don't want to go there now. What we are doing right now on the quality initiative, we work very hard to align the systems that we have with our state office and our regional offices and our support coordination providers to begin to meet what we now know is the centers for Medicaid and Medicare quality framework. To give you a little bit background, every 5 years, your waiver will come up for renewal. Starting a couple of years ago, CMS provided a new type of application that states now have to fill out and complete. They're very based on quality outcomes

for consumers. So that was a real catalyst for all of the departments to begin looking at data and how to measure data and how we would report to CMS that data that showed what Louisiana was doing in terms of quality outcomes. As you can imagine, that was a huge job. For about the last 3 years, all of these quality workgroups have been working on what are the performance indicators that we want to see. That began with the stakeholders. Some of the performance indicators are broad by nature, but some of them are like am I living where I want to live. Am I safe in my home? Can I get around my home? Do I communicate with my support coordinator on a regular basis? Does my support coordinator understand what I want? Do they help me get what I want? It was a whole list of about 50 performance indicators. You can see them all online. We have everything posted. Once we had the broad performance indicators, we then go through a process of deciding which ones do we really have data on and which ones were critical to people's lives out in the community? We began a whole process of refining those performance indicators and putting them in a format that CMS would understand. So we are actually through with most of that process. And we understand

with the help of our consultants. The next step that's going to happen in the next year is our consultants will be helping us work on a self evaluation for Louisiana that will include stakeholder groups. That's very important to Louisiana. We began with input from stakeholders and consumers. We want to continue that process as we go forward. So they're going to help us to put that together. We will bring it back to the stakeholder group to give any input on it. So actually the last 9 months of the grant are going to be really focused on sustainability. We have learned a lot, and we have done a lot. But now we need to be sure all this work goes into the future. I wanted to give you that background so that you would understand somewhat what we were doing in terms of quality. Louisiana is one of the few states that have really worked hard on working across disability groups and across waivers and across program offices. That's why you had all 3 program offices here this morning giving you updates, because we began that way so we would have a comprehensive across the board quality framework. That doesn't mean that each program doesn't individualize to their processes and the needs of their population. If you heard today, everybody's focused on

performance of their contractors and what's going on out in the community, focused on outcomes for people, not just measuring process. But is the outcome that people really are asking for, are they really getting it? Person centered. Is it really about this person, or do we continue to gravitate back toward a medical model? Absolutely, people need their medical needs looked at and managed and helped with. But as Tricia said, none of us are our diagnosis. So even though you have some handicapping conditions or medical needs, you are not the sum total of that. We are all more than that. So we really wanted to incorporate person centered planning directly into our planning process. So it's not something over that we work with. It's a part of everything we do and say and believe. So we are one of the few states who do have this kind of cross waiver assurances in our waiver applications. So believe me, this was big. But the two offices, Office of Citizens with Developmental Disabilities and Office of Aging and Adult Services have worked together to define common quality indicators that they are both using in all of their waivers so that they're consistent across waivers. I think we have done an excellent job of having cross waiver quality workgroups, teams and committees and the self

assessment tool is going to be performed annually by program offices with stakeholder input. These are some of our partnerships because you don't do any of this work without collaborations and partnership. I wish I had the corollary it takes a village to raise a child for this. Someone can help me, but it does take a community. It does take partnerships and collaboration to do this. Some of our partners are the human services resource -- something also happens to your brain to speech patterns when you get up here. Human services resource institute. They have been providing technical assistance and consulting since the inception of the grant. They provided a framework for us to do this work within. It's very difficult to take a very large state system and start to define what each issue is so you can then turn that into performance indicators and outcomes. Our quality leadership workgroup which consists of stakeholders and consumers, they have been incredible. They have given really good input into the whole quality part of it. We will be talking more about that this afternoon when we talk about the consumer report and how do we disseminate reports and data to people who need it to make decisions. Then of course Medicaid, OAAS, OCDD, waiver assistance and compliance, and

health standards have all worked together to come out with a unified product. A little bit about the consumer workgroup which is being lead by Donna Thompson, our very own organizer of this group. She's really taken on that challenge to work with the consumers. The charge to that group is to review quality reports for easy reading and usefulness in making decisions about services or health. I think in terms of where we want it to go or to be was to have some kind of dashboard or indicators that consumers could look at, and it would be online. They can see how one provider ranked against the other in terms of different indicators. I do believe that will eventually happen. DHH is working on a consumer right to know website which will have a lot of that. But in the interim, we thought we would take all the data we had -- not all of it, but data that's in raw form and turn that into information in a report form that people could start to begin reading and educating themselves and start getting enough information to make decisions about providers and how well they were doing. And so we will actually be doing kind of an activity on that this afternoon to give you kind of a taste of that. We also want this consumer workgroup to make recommendations on how and where to disseminate

quality information reports. We certainly want to put it on the internet and the website, but there is still a large proportion of people who don't have access to websites, who maybe don't know how to use that technology. So we want to get this information out in many different ways, many different forms. So we definitely want your input on that. Now I just want to take a little bit time and have a few of those people that are really involved in quality to tell you a little bit about what's going on in those programs. What we will do under this is -- they don't have to but I was going to get Jeanie Level if she wants to talk about quality from the OAAS side and Dena Vogel from OCDD. Then Tammy Terrell in the back is the lead, project director on person centered planning. I will let her give an update on that piece of it. Then we will let you ask any questions that you may have. So Jeanie, I know this is a little bit on the spot.

ROGER AUERBACH: We can ask Dena first. She's been taking notes.

DENA VOGEL: One thing we are working on with the office of aging and support services is a support coordination monitoring process in OCDD. We are hoping to be able to pilot the process in January through the transformation grant. There is funding to help

develop a data system. This is a real complex system. It would be hard to do without a data system to do it because CMS requires a huge amount of individual case records to be monitored. In our case some agencies, we may have to pull like 80 records or so when we do our monitoring. As that data system gets done, then we'll be able to implement statewide. But it's going to be a really good system. It will involve a good case record review where you are looking for outcomes for people. And processes being followed, some of the things Kathy Kliebert talked about, with the plan according to the guidelines she talked about. Was the assessment process done correctly? Is the support coordinator making contact with people and following up according to what their contract says the way they're supposed to? We are not going to just do a record review. We think it is important with people getting services too. So a subset of people will do an interview with the subset of people to see how this is impacting their lives. For example, everybody is required in their plan to have a staffing back up system. If staff can't make it, what are the processes in place to make sure that the person gets the service that they need? Well, it might look great on a piece of paper but if it doesn't

work for the person -- that we can only find out by talking to the person. Do you understand your staff back up process? Have you had to use it? How did it work for you? Do you know what to do if you have a complaint? Do you know who to call? Those types of things that we can only get from talking to the person, not from doing a record review. Also, it will involve actually interviewing support coordinators for the people that we interview, making sure that they know the processes they're supposed to be following, making sure that they understand the needs and desires of the people that they're providing support coordination for. Then the last case of it would be an agency review where we are looking to see does the agency, are they meeting their requirements? Do they have the policies in place they're supposed to? Does their staff have training that's required? Did staff meet the hiring requirements as far as experience or education or whatever? So those kinds of agency things. Like it says, we plan to pilot January, might go into February a little bit. As the data system becomes available, hopefully this fiscal year, hopefully like March, April or so, once the data system becomes available then OCDD would plan to implement that system statewide.

The monitoring will be done by the regional office. Waiver staff and quality assurance monitoring, each OCD office or DD authority district section will be doing that monitoring for the support coordination agencies in their area. It will be done annually. It will be a manual process with each support coordination agency. The only time we might do extra monitoring is if we get a serious complaint about the agency that might trigger more than an annual monitor or something like that. We also implemented this past Fall quality assurance process requirements for provider agencies. Probably about a year and a half ago jointly with OAAS we had developed a provider quality assurance handbook. Last year in the Fall, we had gone around and done training with all the provider agencies, tell them this is how you do it. As we know, we found we can't put quality processes in place every night. It takes time. We knew provider agencies would need time also to put the quality processes in place. So when we do that training, we had told them next July, you are going to need to start meeting these requirements. So we gave them 6, 8 months or so in order to begin putting those processes in place. But the processes we are requiring are the same processes we are required to engage in. It

basically is your typical quality enhancement on going process. You have to have processes in place to review information about the quality of services, what people say they want in their services, critical incidence, complaints, those types of things. They have to be able to collect data and information on that, a process to review that information, and then to develop strategies to improve the areas that they have identified where they're not doing as well as they think they should be doing. That becomes a quality improvement plan. Then to actually implement that plan and evaluate its effectiveness. This isn't a once a year type of process, which is kind of was in the past. We really expect an on going process. Your plan isn't this is my plan for a year. It's as you identify issues, they go on to the plan. As issues are resolved or you see the improvement you were shooting for, they come off of the plan. It's not just once a year. It really should be a ongoing process. Mortality review. In OCDD last year we started a very formal mortality process for home and community based services. We have a mortality review committee that's composed of a nurse, a psychologist, an advocate who is participating through the DD council, somebody from the quality unit. Every death in one of our

developmental disabilities waivers, we collect certain information on that person. I think it's like a month's worth of progress notes from the provider, hospital records, doctor records for the past year, copy of the death certificate. There is an autopsy. If there were allegations of abuse, neglect, results is with the protective services agency. If police were involved, maybe a car accident or something, copy of the police report. There is certain ballistic information we collect. Then there is a review of that. The purpose of the review is really to determine what do we need? Could potentially the death have been preventable? Are there things that either the agency needs to put in place or we as a system as a whole need to put in place to reduce the likelihood of similar deaths occurring in the future? We did have trouble accessing the records that we need to do these reviews. It is very difficult go to a parent whose child just died and say we need you to sign this release for hospital records over the last year or we need you to give us a copy of the death certificate when you get it in. We had approached the legislature last legislative session. We had some legislation passed that gave us access to that information for this very limited purpose without having to get a release of

information. So we can get a copy of the death certificate. We can't release that death certificate to anybody else. In fact the legislation even protects that information from being subpoenaed by a court. So it's very, very specific for the mortality review process that we obtain that information. We also have established a clinical review committee. We hope to, over time, have a risk management process that we have been working on go into place. The clinical review commit see broader than the mortality review committee. It also includes OT specialists, PT specialists, regional office staff. It's a larger group. What they do is certain critical incidents when somebody has maybe a suicide attempt or 3 hospitalizations within a certain period of time, there are a few we have identified, eventually we want to expand this. But we will gather some information. That committee again is seeing is there a way we can work with that person's team to put in place -- it's a preventive type of thing. Are there things we can do to put in place in order to reduce the likelihood for this person of these kinds of issues coming again, happening again. Also look for trend data. Are there things we are seeing across situations that we can implement on a broader basis that might have an impact? I am not sure how

soon we will be able to get to it, but eventually what we want to have is a 3 tiered system where if certain events occur -- suicides might be one case. Hospital admissions might be more than one. It will depend upon the type of critical incident. But if certain triggers for each critical incident are met, there would be a mandatory meeting of that person's support team where they have to do certain things and consider certain things. If that improves the situation, then that's as far as it would go. After that team meeting, if a second trigger is met, it would trigger review at the regional level. There would be -- what kind of assistance can we give the team to have an impact. If that doesn't result the issue for the person, there would be a third trigger where those situations would go to the statewide review committee. I am not sure how soon we can get to this because it will take some planning at the first level and the second levels with those teams and the support coordinator agencies and the regional offices have been so involved with learning the planning process and new assessment process that we really couldn't put some other thing on them at this time. But when those are all under control and that situation is flowing the way that we would like to see it, we are sure that all the training's

been done, then at some point we are going to be beginning to implement this risk management system probably phasing it in. So we'll start with some critical incidents maybe for the first 6 months and then bring some more on at a later date. That's what we are planning for the future. We are also updating our complaint system in OCDD. Beth has been working on this with the team for about a year now. The year and a half prior to that, we had a real rudimentary -- guess that's the right word -- system in place. We collected some basic information on complaints. We did have a tracking system. It wasn't the most up to date technology but it did track it for us. Then we knew it wasn't what we wanted. But without some experience, we felt we really didn't know what we wanted. So we had always planned in about a year, year and a half with experience with the system, we would get the people together that are using it to see what do we need to do to improve this. They had been working on that. The computer system is almost done. It will be a really great system. It's going to be a web based system. Before, we were just able to track real broad categories of complaints. Like I don't like something about the environment, but with no details. This system will be

able to get finer grain details which will help news quality improvement effort. If the categories are so broad, you don't know what to do to improve the situation with more specific information. We'll be able to use that to make system improvements easier. With that -- we are still planning January?

AUDIENCE: Yes. We are doing testing with the new data system in January. We have actually already revised and updated the draft policy. We'll be sending it out for comments statewide in the next few days actually. We hope to have it up and running by March or April statewide.

DENA VOGEL: The other quality initiative I want to talk about is we set up quality processes within our regional offices and districts and authority. This has been part of the human services inner agency council and human services accountability and implementation plan. Within the accountability and implementation plan, it does require there to be performance outcomes for each of the program areas that are involved which is mental health and addictive disorders as well as developmental disabilities. Again it was probably about a year. We had pulled together a workgroup that includes regional office staff, district of authority staff, central office staff.

For all the functions of the DD sections of the human services districts and authorities and the OCDD regional offices, we identified performance indicators, that group did, so we have about 28, I believe, performance indicators. And they're reporting them. They started the first quarter of this year, reporting data on those performance indicators on a quarterly basis. Then we have a process once a year do validation visits with each of the regions and districts and authorities. What that involves is we kind of go out there, and these are the numbers you reported to us, we want to see your back up documentation. Your computer print out or whatever verifying the information you gave us. For areas that performance indicators are not being met, we want to see their quality enhancement plan with the strategies they're employing in order to bring their performance up in those indicators. We just did one of these yesterday with one of the regions. They went there. They said our numbers aren't correct. They didn't have the data. They had to run the reports for us. They didn't realize they had to have that for us. I said it's like trust to verify. We want to validate what she gave us. We'll be doing those with every region and every district and authority once a year. I can't think of

anything else. Can you?

TAMMY LEBLANC: By the way, she updated you on the IT part too.

AUDIENCE: I promise not to repeat anything Dena talked about. It is true what Tammy talked about earlier that CMS has really overhold their whole way that they evaluate quality and that they expect us to monitor and evaluate services that go out to people. This happened about 4 years ago. It's coming down where the rubber meets the road in that our actual labor applications have the performance measures built into them now. So across OAS, across OCDD, if we don't already have those measures into our waivers they're going into our waivers. One thing that brought all that home was our recent evidentiary based reporting that had to be submitted to CMS at the end of September. That was a lot of worked. That helped us look at more objectively where we are now and where we are headed towards with quality measurement. As Tammy mentioned earlier, as far as our performance measures when it comes to CMS, we have to use measures that we actually have data for now. We actually have a number of interim measures based on the data we have now. We are working towards future measures that are based

on some of the new processes for measuring quality being built such as the support coordination monitoring process Dena just described. Then another big process for supporting people and getting better measurement of services and for supporting the support coordinators in providing better health and welfare for our participants is the electronic plan of care. Being billed on both sides of the waiver world. OCDD is in the process of getting electronic client care and so are we in the office of aging. Sorry. I can't read my notes. Anyway, the evidentiary report really helped us scope out where we are now and where we are headed. In January we'll actually begin our official cross waiver quality committee meetings where OCDD, OAAS, health standards, Medicaid, we regularly meet, discuss quality issues and how we can be uniform whenever possible as far as quality measurements and quality processes. So we are excited about those committee meetings. We have had lots of cross labor quality meetings, but these are more formalized. The process will be formalized as spelled out in appendix H or quality section of the waiver documents. OAAS has implemented recently death review committee. A lot of focus is on reviewing data and identifying program changes where needed and

identifying that proper referrals were made. Also the committee that will be reporting to the legislature. Another area that's been important to us is risk identification and mitigation. As Dena mentioned earlier, critical incident categories themselves can help you identify people who are at higher risk. For example we have critical incident categories for self endangerment, suicide threat, falls, major injury, medication error. These are all very risky people that could have prevention actions taken. Finally, I know Tammy mentioned a lot of the measures that are built into our Louisiana consumer survey. That's very good information. It went into our evidence report. Another thing we are looking at is how do we take this information? How do we get more representative information about what's happening to people? Surveys are based on a representative sample, but would it be possible to get some of this information on 100 percent representativeness? So we are looking at ways we can build those type questions into the plan of care where there could be near term action taken to solve whatever the problem is. Alison, do you have anything you want to add about our projects? Any questions?
AUDIENCE: The meeting you were talking about, are

they open to the public?
AUDIENCE: These are working meetings. We have several committees. Some of the committees are stakeholder kind of committees. The one I described was an internal meeting to basically fix problems.
AUDIENCE: I have a question about the death review committee. I want to know more background on OAS side of the death review panel.
ROGER AUERBACH: Question about the death review panel and what O A A is doing, more information.
SPEAKER: Alison, do you want to summarize, or do you want me to? We are really at the beginning of the process. We are getting some guidance from the consultants. Val Bradley has done a lot of work in this area. Just basically, it's taking that data, that information to move forward and make changes. Also, we have a process set up as Dena described with the critical incident reporting process. And death is a critical incident. So our regional staff with every death are responsible for closing the incident, which means at that point in time, they're identifying whether all actions, all referrals, everything that needed to occur occurred. At the higher level of the death review committee, we would be looking at aggregate data and what can we do

about it to make things better.

SPEAKER: I wanted to add to help you out, the legislation Dena was talking about, OAS was included in that to make sure it would be easier to obtain data. OCDD and OAAS together as far as mortalities were concerned were both with that legislation.

AUDIENCE: I want to add one thing. She mentioned evidentiary report in September. It may have been in the first part of this month. CMS sent out waiver team from Dallas. They have regional offices like we do. They came out to follow up on that report and looked at our actual processes and actually got a copy of our 372 report which is our financial report. We expect a report on the quality -- assurances. I have over waiver assistance and compliance section. That's what we are talking about here. CMS is a mythical giant in the sky. But they have a reasonable office. We work closely with them. If Dena or if the program offices need you to change something or approve something, it's not harassment. CMS looks at this. Like they said about 4 years ago they got serious about quality assurance. To pat the two offices on the back, I think the team that came out and looked at 100 plans of care from each program office, and there were 2 that were not renewed

properly. I think even after the fact those two we found that we showed the review team that they were. So as I informed it from the review team which gave us a good report have been Ally, it was like 200 out of 200 plans of care. They pull them at random. They gave us names, but we didn't choose to show them what we wanted to show them. So it's real stuff. It's not what the program offices give to us and we send to CMS go in a sock drawer. They look at what we told them real time. I appreciate it. If anybody can help us more I would appreciate that from Medicaid's perspective. Thank you.

DENA VOGEL: We do have some of these reports public for OCDD. Like Tammy said the websites, I don't remember because it's not an easy address. If you go to DHH.la.gov and under offices go to OCDD. On the main page on the left there are areas you can go to towards the bottom. There is a quality piece. When you go to the quality page, we post our mortality. Two years ago we did a mortality review. Medicaid asked us to do that. Then we put an official process in place do this on an ongoing basis so we kind of missed a year as we were developing the process. But right now we are completing our mortality review for this past fiscal year.

Once we complete the report and it gets approved by the department and by Medicaid, then we will post it on our website so you can see our mortality data for OCDD waiver services. As well, the consumer surveys we do, we also analyze those results. State to state comparisons are done by national core indicators project. We post those on that website so you can see how Louisiana compared to the other states that participated. As well, we do instate comparisons. So you can see the results between regions and between program areas. Those are also posted on our website and each year as we analyze those, we'll continue posting both the mortality, annual mortality report as well as consumer data there. And as we develop additional data and reports that we think people would be interested in, we will see about posting it in that quality section.

SPEAKER: Alison suggested that maybe I didn't make it clear enough that we are looking -- death review committee realize elderly people do die eventually. And we are looking at aggregate data. We are looking at aggregate data and what we can make a difference on. For example, death with fall. What are our numbers? Is it getting better? And how we can improve, what

program actions we can take to improve things. Any questions about that? Thanks.

TAMMY LEBLANC: Thank you all. That was very comprehensive. Tammy, I am going to let you talk about person centered planning. As I looked around the room, I realize that there were a lot of new faces here. So I plan to put up a chart of the offices where DHH, Department of Health and Hospitals is at the top. You can see that it is Office of Aging and Adult Services. This is what the different departments are. Office for citizens with developmental disabilities with those. Bureau and health services findings. Waiver compliance and health standards. I realized after the fact that there were a lot of new faces and didn't know if you understood how we were structured. I will go ahead now and let Tammy Terrell talk about person centered planning.

SPEAKER: What I am going do today is introduce myself first. Tammy Terrell from the Office of Aging and Adult Services. I am going to ask for your participation in helping me to explain to you what we are dog with person centered planning. So I would like for you to imagine that you were working in New Orleans, a wonderful place to work mighty add, and that you were

there maybe Monday or Tuesday when it was raining and raining and raining and raining. So your car was parked on a low lying street in New Orleans, which they have a lot of them. When you came outside, there was water in your car because it flooded. But after the water went down, you were able to start the car. You came on back to Baton Rouge, Denham Springs or wherever you live. When you got there, you felt comfortable, happy you made it home. When you tried to go to work the next day, your car wouldn't start. So you called your insurance company, and you talked to the insurance agent. They said well, we are probably going to have to total your car. So we need you to let us know what happened and what you would like to get as far as a new car is concerned. All right. So tell me some of the things you would like to see in your new car.

TAMMY LEBLANC: I want mine to be a Lexus.

SPEAKER: Okay. What did you have before?

TAMMY LEBLANC: A tini tiny Saturn.

SPEAKER: Okay. Anybody else have some preferences?

AUDIENCE: BMW 650 I.

SPEAKER: Wait a minute. I didn't say what type of car. I said what type of features. I didn't say features. What

would you like to see in your car that's probably a little comparable to what you had?
TAMMY LEBLANC: What was the question again?
AUDIENCE: 6 C.D. changer.
AUDIENCE: Seat warmers.
SPEAKER: In Louisiana you need heated seats?
AUDIENCE: Yes.
AUDIENCE: USB connection for your MP3 player.
SPEAKER: You have that already?
AUDIENCE: Vehicle that's further off the ground.
SPEAKER: Thank you. Something that sits a little higher.
AUDIENCE: Good gas mileage.
AUDIENCE: GPS.
SPEAKER: Navigation system. Okay. Why do you think I am asking you this? Why am I asking you this as the insurance agent when you are about to get another car?
AUDIENCE: You are planning.
SPEAKER: We are going to plan for what you want to have, understanding your needs and also understanding what you had before, Ms. Go from the 1990 Volkswagen to the 2010 Lexus. Which also have to consider what? More than anything, what do we have to consider?

AUDIENCE: Cost.

SPEAKER: Thank you. Okay. So you talk to the agent, tell him all the things you want. 6 disk C.D. changer, navigation system, heated seats, USB connection, vehicle that's higher off the ground, good gas mileage. Tell him you want this Lexus even though you had the 1999 -- 90.

TAMMY LEBLANC: I think the Lexus has all those things.

SPEAKER: I am sure. So the agent calls you back. He tells you okay, here is what we have for you Ms. Tammy Leblanc. You can get a car that does not have heated seats. We are going to maybe include a little money for you to buy a Tom, Tom. You won't have a navigation system included in it. Unfortunately it's a car that sits lower than you had before. You may have told him based on your experience that I don't want electronic anything because when I got back in my carry was scared after the water because of all the electronic systems. He tells you something that you can get that includes maybe half of what you asked for or half of one item. How do you feel about that?

TAMMY LEBLANC: I don't want half a Lexus.

AUDIENCE: Deprived.

SPEAKER: You feel deprived. You feel like the fact he asked you all this made no difference in the world. So in person centered planning, what we want to do is assess our clients, listen to what they said they would like, listen to what they say they are used to having. The elderly population is unique because we are not trying to plan for their future as much as we are planning based on their past. If we have a client who has an educational level that's high, that's worked in a certain career, that's lived in a certain area for a long period of time, we want a plan based on what has happened to them in the past as opposed to a population where we are trying to plan a future. So we want to make sure that we consider the things that they have experienced in their lives before. We don't want to listen to what they say but then not accommodate what they say. Okay? Congratulations, you have been introduced to one of our tools we introduced our support coordinators to in February. This is our preference map. What we did was we introduced them to 3 tools to help them to organize information that they gathered in the assessment process. So in the planning, they can person center their plan based on the information they gather about relationships, about their routines, and about their preferences. Okay? Anybody

have any questions? Comments?
TAMMY LEBLANC: Am I going to get my Lexus.
SPEAKER: Yeah, I am going to draw it for you. Any questions, comments or concerns or anything? Everybody got kind of a clear picture of what person centered is about, and this tool? Thank you.
TAMMY LEBLANC: I know except for Tammy who really had this energetic exercise a lot of what we talked about was really technical and parted of our operations. But the kind of take away on quality is that we really did start with what the stakeholders wanted in the broad and are now operationalizing it. And we are now down to the person, the actual consumer, and working with them to get what they need to have a quality of life in the way that they define it. So that really is, I think, the take away. We want to make sure that by doing these things, that all this good work continues after the grant ends in September. So that's quality. I was going to say in a nutshell. I am not sure if it was exactly in a nutshell. One last chance for questions. Now we go onto information technology. Let me switch slides here. IT stands for kind of information technology. If you think quality, what we talked about was technical, this becomes very technical. So I am not really going to talk

in real technical terms. I wanted to let you know that from the beginning, we wanted to design this information technology systems so they would actually support what we were doing with the quality initiatives. In many cases we were doing quality work. But there was no way to measure it. For ourselves and for our consumers and for CMS, we had to have some way to take huge amounts of data. I mean, the amounts of data that we have is astronomical. But it doesn't mean anything to our brains and our minds if it doesn't somehow get translated into a form that our minds can read and understand and make sense of. So for the information technology, it really was an objective that got pushed back a couple years simply because we didn't have a director or a C I O of -- a director of information technology at the Department of Health and Hospitals. So we weren't able to go forward. Once we did, we went forward very rapidly. We assessed the program offices to see what gaps we had. You heard about all the quality we were doing. Here it is. What we had to report to CMS, here it is. There was nothing -- well, there were a few things but not really anything practical to join all of those systems together. So we started saying what do we need? Then we started talking about

what IT systems do we need to really get to the quality outcomes that we want, to measuring the quality outcomes? It's really 3 projects, but two of them are mirrors of each other. What was happening is we had a very fragmented system. So we decided to start at the beginning and to start at a place where we can start collecting data on consumers. We are calling that a participant tracking database. It can also be called a census database. What happens with that is you have kind of an entry level or a face sheet that anybody in the system can use, including providers if you want them to, including what we call our single point of entry, which we have a contractor doing. Then we have another contractor as a pilot. So what happens is you set the level of security, but now you have a web based system that whoever is taking a referral -- beginning with the referral they can go into the space system and start getting information on this person. They may get the name, the address, who their primary contact is, who their secondary contact is. Maybe age and some identifying information in terms of beginning eligibility. Do you have a disabling condition? What is your income? Some very basic questions. At that point, that information stays in the system basically forever so that

winnow that this person called in and was interested in services. Then they have some pieces behind that face sheet. Let's say the referral now goes to the office for citizens with developmental disabilities. Their intake workers or their assessors can now open up that page and see what information has already been collected. They can gather more information about the person and put it into the system. So you kind of keep going with this system so you have an entire history of this person. And it includes things like if they were denied services, if they wanted an appeal, when that appeal was done, what the results of that appeal were. It could be someone that for instance thought they were going to be in the elderly system but instead is referred to mental health or to the offices for citizens with developmental disabilities. It is kind of like that record follows the person so that any department that has access can now coordinate and have the information that they need. That's kind of the system that then becomes the centralized system, where if you need to bring in other information from Medicaid systems, it can flow through this census page or this participant tracking. Or if we come up with any other systems in the future, there is a way to connect them so that they share information. I

think the important part to take away from that is that it's at a security level that's appropriate for that person. So for example, if support coordinators would have access to it, they would only have access to the people that they are serving. They would have no access to the rest. If the Office of Aging and Adult Services needs to collect data on everybody in their system, then they can do that. But they wouldn't see people who are now completely transferred to OCDD because they don't have a need for that. If OAAS got together with OCDD and wanted to do a 100 percent census of everybody, then they could do that and get that information. You can get information by Medicaid waiver if you had access to it so you can start to draw information. In other words, many times when we get reports, you are never 100 percent sure that you are not duplicating people. So this system would give you a way to have what they call clean data. You know you are not duplicating. So when you go to the legislature and they say how many people are in the waiver, you can give them all of that information. We can get that information right now, but you might be taking it from 3, 4, 5 different databases, and you are not 100 percent sure that you are not duplicating. So it becomes your foundation for

all other systems or modules or pieces or databases that you might want do in the future. That was like a really big step and kind of the framework of what we did with the grant. The other piece that we did jointly, you heard Dena talk about it and maybe Jeanie a little bit, is support coordination monitoring tool. We wanted that automated because of the vast amounts of data that we then need to aggregate to -- let me back up a little bit. A key piece of quality in a longterm care system like what we have in Louisiana is support coordination. They have a really valuable role but a very tough job because they are really the group of people that understand the holistic picture of the person. So they really know the medications. They know the medical conditions. They know if people seem to be declining in health. Or they may pick up on something. So their quality role is crucial to everything. Because of that, we needed a system to really identify the wore elements. -- core elements. What does that look like if you are going to be a quality support organization provider? We have that on our website. I will not go into it because it is very internal and it is technical in the sense that only if you work with it a lot will you understand it. But what will happen is based on the elements, you will be able to

give a score for each element. Then you will be able to get an overall score. As we understand more and more about quality and support coordination, we will understand that point where the score is satisfactory or below satisfactory or above satisfactory. So we need to start by getting information and doing pilots and doing field tests. That's called kind of a baseline. You need to see where you are, where you want to be. Then you need to work towards that with training or other types of interventions. Do that, it takes a vast quantity of data. Again, our minds, we can't just look at raw data and our minds make sense of it. We have to get it in a form that our minds can understand. That's the purpose of doing what we call the support coordination monitoring tool. It's to get all of this data into a system that then puts it into a report that we can share with support coordination, show them where they're strong, show them where they're weak, show the system where they're weak. Then we can start pinpointing where we need to go with support coordination and where we need to go with the system to get to a quality outcome in support coordination. Now, let's not forget we have all these other quality initiatives going on all in other places. But this focus is on support coordination which is crucial

for the holistic quality of the person. So without going into anymore technical detail, that's what we are trying to achieve with our IT system. To link it to quality and get information in a form we can understand to make decisions. So do you have any questions? I know I haven't given detailed information. But I will be glad to answer something if you are more technical.

AUDIENCE: I guess that's what my question is. -- I hear from the DHH side like where you want to go with it. Are we talking about the development of the system or do you have the system you want to implement to the providers?

TAMMY LEBLANC: That's a very, very good question. Let me repeat what you are saying to make sure I am understanding. You want to know if we have a system in place already that's automated, or is that the part we are building?

AUDIENCE: Yes. We are trying to figure out the components to the system or have you already gotten to that phase?

TAMMY LEBLANC: We have the components. We are actually going to go out with a paper version just to get more information about how the process works. In the meantime, we are working with an IT person who is

taking what we want in the program or programmatically interpreting that or translating that into this database. It's really a database is what it is. That database is going to have a component that automatically generates the reports from the data. I can't get anymore technical. Do you want to know more?

AUDIENCE: No. You know what you want. You interpret that to a technical person and let them figure out the technical standpoint. The other question is on the provider level, once you get that in place or ideally -- I don't think you actually have this in place yet but ideally, do you want that to be we retrieve the data and put it in the system or we submit that data to you? Is it something where we purchase the system?

TAMMY LEBLANC: Another thoughtful excellent question. As far as the grant which is only 9 months, I don't have any clear answers to that. I can say at this point with what DHH is doing, there won't be any cost to the provider of implementing it. The only cost would be for instance if you want a separate program say to take all this information and put it right into your payroll system. So for the provider, it would only be if you want to add on something.

AUDIENCE: So there will be a capability to interface?

TAMMY LEBLANC: When we went into the RFP process, there was. The RFP process is in someone else's hands. So I can't tell you that it will be. But I know we put those in writing and they have it. So, yes, I can tell you that part. On the support coordination tool, that's just internal. There is nothing at all that providers have to do with that. So there is nothing they have to buy or anything like that. They would get the report. Then whoever is working on it from the regional level will go over the report and say this is what we found. This is how we found it. We found maybe you are not quite understanding how do a CPOC. How do we go about giving you training on that? How do we get your quality up or something like that. That's what that's intending.

AUDIENCE: What is CPOC?

TAMMY LEBLANC: Good question, Roger. It's a comprehensive plan of care.

SPEAKER: Dena and I were talking. We wanted to help you out a little bit with the questions. Database, web based, so you will have access. It is not intended to be of cost to the provider. As far as the information, getting it out of the database, we will have to tell the programmers the reports we want the system to be able do, which we are working on that process.

AUDIENCE: So it will be like a scheduled time to input that information? We kind of discussed CMS. For instance every quarter we go to H B MS where we put the information in. Will it be similar where we put the information in and you work the raw data from there.
SPEAKER: Yes, we will have our individual policies and procedures.
AUDIENCE: I have to put it in.
SPEAKER: It will not take the place of SSI and the process you have with them. This system now is basically a census for us. Let me give you an idea with OCDD D. We have Early Steps program for OCDD. That's one database. We have people with the waiver. That's another database. Some state funded services are in a third database. We have people receiving services through the public supports and services center. That's a 4th database. We have people that are in private ICF/MRs. That's a 5th database. There is no connection between them. We could have somebody that comes in is eligible, gets Early Steps, gets state funded services. Then maybe they need ICF/DD services. Then they transition out and go back to community services. There is no system where you are following that person all along. That's the purpose of

the census system so we can go to one place to know who all is getting services and kind of track them so we know where they have been in the system and kind of where they are going in the system. It will not as far as providers go take the place of the way you currently do your billing with S R I and pre, and post authorization process.

AUDIENCE: I don't know what S R I is. I don't know that system. But more I guess for clarification. It is not a program level report. It is more participant level reporting.

DENA VOGEL: Yes, yes. We eventually may get to other components but not now. Another component we are working on now is a provider component. Now we don't really have a system to know all our providers and what their addresses are, how to get in touch with them, as they have changes in phone numbers, to be able to do that. If there is information we need from providers such as what's your turn over rate or whatever, we don't have any way to do that. We are also working on a provider database too. That database providers will have access to they can report to us as they have changes in addresses and phone numbers and things like that so we know how to reach them.

TAMMY LEBLANC: Let me clarify also. I thought when she originally asked the question because you had asked about the DHH, I thought you were talking about the call based billing which is another -- after I started hearing answers, I was like okay, I was off. It was something we talked about here a year ago. It's still in the works, getting ready to be an RFP. But call based billing happens at the consumer or client or participant's home. Any time a personal care attendant goes in or a healthcare worker or a supervisor, they would pick up the phone and they would call into the system. The system automatically records it. Then when they are leaving, they would call in again to say they're ending the services but there would also be codes to say while I was here I gave the person is bath, we went to the doctor or whatever it is. That information automatically goes into what they call the prior authorization -- it all happens electronically all the way to billing. So that at some point if you are a provider of say personal care services, or if you are home health, you will be doing all of this electronically. Then it automatically generates payment to your company. So I thought that's what you were asking about which is why I talked about if you wanted it to connect to your payroll. What we were

talking about is totally different. I didn't mean to confuse you.

AUDIENCE: On the same line would you explain that you are looking at the components. You are looking at the components of what you actually want to do to build the IT system to house quality initiatives. I thought that was the answer you gave me.

TAMMY LEBLANC: Still the answer. I just wanted to clarify the systems. Thank you for bearing with me while I did that. Any other questions about IT? I think everybody saw the food arrive. Is it okay with everybody if we break?

ROGER AUERBACH: Can we give people a preview of what we will do this afternoon just so we can tempt them to stay around.

ROGER AUERBACH: Not just because we are getting more cookies.

TAMMY LEBLANC: We are. This place bakes the best cookies. You really want to wait for that. I am going to give an update on housing which is the last goal. We have gotten through two goal areas. I have one more. But I think the real core this afternoon is we are going to be taking a look, when we talk about data and IT, an actual report based on actual data that we have gotten,

it's been put into what we think is an easy to read, easy to understand, easy to make decisions about report. Donna Thompson will give you a report. She's already kind of sent it out to consumers to read it. We'll give you a report on that. But we are actually ask you to read the report in small groups and to answer some structured questions about how easy you think it is to read. What about the graphs? Were you able to understand them? Also could you make decisions based on this? If this is a type of report that you are interested in seeing, we want to start working on all our other data putting them into reports that are equally as easy to read and understand and to use. That's the crown and glory of our meeting today. So I really do hope you can stay.

ROGER AUERBACH: The sandwiches are in the back. There are different types. There is a little sign in front of them. Tammy, we will go for a half hour?

TAMMY LEBLANC: Donna who is organizer said 45 minutes. But we can see how people are at a half hour, if they're ready.

ROGER AUERBACH: Thank you. Okay. So we are breaking. Thank you.

ROGER AUERBACH: We are ready to begin for the afternoon. Tammy is going to finish up on the last of the

3 goals which is housing. Then we are going to go into small group session. Tammy.

TAMMY LEBLANC: After housing we are going to include a short update on money follows the person. Then we will go into that. Housing has been terrifically active over the whole 5 years of the grant. To give you a quick update, we now have a permanent supportive housing division or department with Chris roar who is heading it. We are using permanent supportive housing actually for a lot or we are trying to align the systems for our money follows the person initiative so that we can -- as people want to exit nursing home or developmental center, we get them an application and help them fill it out. They are actually then referred to the permanent supportive housing local lead agency, which is at the regional level. Permanent supportive housing is only available in kind of the Southern parishes below Alexandria. Those affected by Hurricane Katrina and hurricane Rita just because of some of the legislation that had to do with housing at the time. Along with the permanent supportive housing, advocates successfully lobbied Congress for 3,000 vouchers for people that need permanent supportive housing. 1000 of those vouchers are for the homeless in the shelter plus

program. 2000 are spread according to the allocation across disabilities. That is homeless, people with mental illness, people with developmental disabilities, people who are frail elderly, people with physical disabilities, and youth with disabilities transitioning out of foster care. So even though permanent supportive housing has been operating for about I would say 2 years now, we are in the process of aligning our systems so people in money follows the person can actually apply. There is only a window of opportunity. They will open the application. Then they will close the application. They may open the application process at a different time and close it. So we are trying to make sure everybody is educated so people can apply at the right times to get housing. So the money follows the person folks can talk about that more if they wish. That's what's going on with housing in terms of what has happened in the past and where we are. This is what we are working on now. Advocates went to the Louisiana consolidated plan meeting. Write that down because it's a very important meeting. If you want to impact housing for people with disabilities, it is very important to show up at these meetings and talk about what it is you would like to see funding in Louisiana go

for. There are lots of groups there all advocating for what they believe they need. So if we don't speak up in one voice for what people with disabilities and the elderly need, then we are not heard. So it is a very important meeting. In that console day Tim plan through the advocates' efforts they have put aside 500,000 for a program called tenant based rental assistance. It acts like a regular section 8 voucher. I said acts like. But it's a bridge subsidy. It is not meant for people to stay on year after year after year. It's meant to help people -- it's mostly to help people come out of institutions into the community because they have support, and they have support coordination who can help them get on section 8 waiting list and help them to get other types of funding to help them to stay in housing. So it's really a bridge subsidy is what they call it. The RFP for that is coming out, I heard today, but maybe by the end of the week. If you want to look at it, any agency is welcome to apply if they have a plan to do this. As a state, we are actually trying to find an agency in north Louisiana. We would assist them. Apply for this RFP. If you remember we have permanent supportive housing in the Southern part of the state but we don't have any programs for housing in the northern part of the state. So as a state initiative

we would really like to see these home tenant based rental vouchers be a part of our northern kind of plan to transition people. So we are working on that, I would say as I speak, except I am here. But yesterday and then tomorrow I will be working on it. In this new administration with President Obama, he told the secretary of HUD that he wanted to take a look at all the unused housing vouchers. You know what I am talking about? Section 8 housing vouchers. You get it, then you look for a house and it pays part of your rent, subsidizes it. At the time they did it, they found there were 4,000 vouchers in the United States that were currently being unused for whatever, whatever the time span. Say a year. Believe it or not, that does happen in places where it is difficult to find housing. The public housing authority will get an appropriation based on their population, but there may not be enough housing. Or you can't get the landlords to agree to take the voucher. So they can't use the vouchers. So they just kind of stay on the books. He told the secretary of should to find all the vouchers which he did. They identified 4,000. As of the latest counted, it was around 6 thousand. They put together a special program at the federal level where public housing authorities are going

to be able to competitively compete for these 4,000 or 6 thousand vouchers under 2 separate programs. But both of them are geared toward nonelderly people with disabilities. The background on that is there was a movement at one time to become elderly only. When they did that, a lot of people with disabilities lost their housing. Then there became a really big need for housing for people with disabilities. In one of the programs, it is to target people with disabilities who are nonelderly, who are already on their waiting list. If they competed for that and go through their waiting list and they would start to give vouchers to people with disabilities. They go through their list. The other one which we are working with with I think maybe 9 to 12 kind of large public housing is is to see if we can develop partnership. They would apply for the vouchers and then would distribute them to people on money follows the person. What we would do as a state is we would actually give them all the documentation. We would send them with a letter saying this person is already eligible through money follows the person. Then the public housing authority would know and they would give them the next voucher on the list. What we would hope to do is to find a public housing authority or

a partner who would be willing to do the entire state. Or maybe two partners, one in the north and one around the southern. We are meeting diligently meeting with the partners to see if we can do that. It's a N O F A. That's what should comes out. It has not come out yet. We are waiting for that. In the meantime, we would like to have partnerships lined up so we can do this. I want Alison Vuljoin to talk about assisted living but I will put it to last so I can go through the other two. Then she can talk about assisted living. Sustainability. We were doing what we call community housing advocacy networks in every region around the state. Those were very successful in terms of pulling together people to really advocate at the state level. But it was less successful, we found out from doing it, at the regional or local level because you don't have a lot of funding at the local level. So about halfway through the grant we changed our strategy. With the assistance of the ARC of Louisiana where we have a partnership, we started providing training on affordable housing in 3 meta regions around the state. Alexandria, Baton Rouge and Lafayette. Those trainings have been on rural development, which has a very good -- if you want to do homeownership single family habitat. We have been

working to give information for how to help people get into rental units. We had a very good training by the public housing authorities on how they calculate rent. We say as a matter of doing a shortcut, 30 percent of rent, utilities. There is lots of variables. So it really is important if you are working with people on housing that you understand how do that so you can calculator know what rental price you are looking for in your community. So that I thought was very well attended, very well received training. In this next year, we are going to focus on helping nonprofit providers, people who are traditionally not wanting to build housing, to see if we can get them actual hands on development training. How would you develop if you wanted to assist people with homeownership and kind of finance or partner with them or whatever. How would you go about developing single family housing? If you wanted to do small multi family, how would you go about actually developing that so you can get to the point where you can actually get financing for it and then build it. So that's going to be our focus in the next year. We are partnering also with Louisiana housing finance agency. The easiest most flexible set of funds to use for that is something called H O M E. We are going to have a representative from

Louisiana housing finance agency talk to the groups in training about how to use H O M E dollars to actually build either single family or multi family homes or apartments for people. Then we will go on and we will get a more extensive training that's more in depth. We might be working with neighbor works which is a national organization. These will be some quality programs. I send it out to all my mailing list. We have a good mailing list now. I did want to mention this specifically to the folks here who also touch other people in their organizations to really let people know what's going on. These are free trainings. Really encourage people within your organization to attend because it could really be a way do small scale housing but on a large scale, across the state. Kind of a little bit in each place adding up to a lot of housing. I just really encourage you do that. In terms of sustainability, in your packets, there is a membership form for Louisiana housing alliance. Louisiana housing alliance is a statewide advocacy group. Its mission is really to lobby the legislature for legislation that is favorable in terms of housing to people with very low incomes, and they specifically talk about people with disabilities and the elderly in terms of housing. They hire a lobbyist,

something we are not allowed do, to actually work on this issue. They hold meetings where all constituents, all the members can go. They actually prioritize what they're going to work on. It's another place that if your voice is not heard and if it doesn't continue to be heard, you are not as a group going to stay on the radar. We were able to stay because of the grant. We were able to stay on the radar at all levels of the state with housing. We really want to sustain it. I would just like you to really consider with your organization or organizations you know to join the Louisiana housing alliance as a member so you can continue to advocate for people with disabilities and the elderly. I talked about ARC of Louisiana. The other thing that I don't have on here is Louisianahousingsearch.org. It's a database that's online. It's backed up by a call center where they have live people who can answer questions from any citizen in Louisiana. But more specifically, people with disabilities and the elderly who need more physical accessibility accommodations. You can either go online and put in search criteria and find housing in your area. Or you can call the call center and have them help you. The really good thing about this call center is all of these listings are up to date within 10 days. If they don't hear

from a landlord in 10 days, if there has been no activity on it, they will E-mail the landlord saying is this still correct? If they don't hear that way from the landlord, they will call the landlord. If everything is good and up to date, fine. If not, they will actually temporarily take the listing off. So when people are looking for housing and they call, it is up to date information. The apartments are there and ready to be rented. It's by subscription. So after the grant of course which is paying for it now, that will go away, but we have already spoken to Louisiana housing agency, LHFA, Louisiana housing fans agency, who has agreed to put it in their budget to go before their board so they can continue to have this service in Louisiana. It's going to come down to the wire and we actually won't know if their board has approved it until the Fall of 2010. But we will continue to try and get updates and remind them about it. So let me ask you before we go into assisted living, are there any questions about any of the items that I have spoken about or on housing in general?

DENA VOGEL: Are the CHANs still going on?

TAMMY LEBLANC: Kind of morphed. I guess the direct answer is no. It's morphed into the training for the mega regions. But it is still that core, the group of

people that would have been attending the CHANs. Any other questions?

AUDIENCE: You talked about the RFPs coming out for bridge subsidy. My question is once it comes out when do you see it going into effect?

TAMMY LEBLANC: She asked about the RFP and when do I think it will go into effect. What I understand is it will be on a real quick timeline. They will put it out this way. And applications will probably be due at the end of January. Then they're going to give you a time line to implement it. I can't really tell you that because whoever gets the RFP, that's going to be contractual between them and LHFA. If I was saying overall, I would say between the spring and summer of 2010. Any other questions? I think I will now turn it over to Alison Vuljoin who has been working on assisted living since the inception of the grant.

ALLISON VULJOIN: Adult residential care. We have licensing standards for adult residential care and providers are currently allowed go through the facility interview process and obtain a license. They were allowed to begin November 1, although no providers to my knowledge have obtained a license as of this point. I think one of our biggest accomplishments is on the

slide. We worked with Louisiana housing finance agency to amend their application and put it in the qualified application plan to accept applications from interested providers for the low income housing tax credit program and to kind of allow them to be able to compete with other housing applicants to develop housing programs. There is a lot of analyzable space in assisted living because -- analyzable space in assisted living because of the place for activities and so forth. We need to amend these to allow these to compete with multi family housing. LHFA agreed do that. So in this next funding round, we expect to have projects who are going to be able to put in applications to hopefully obtain financing for their projects. We have our consulting firm that's on contract with us working with 5 demonstration projects located in the Alexandria and Monroe regions. I know of one project that she's working with that will put in an application possibly too. The waiver that is going to fund the services in the housing, which is what makes for part of the affordability and makes these projects work will be implemented July 1st in the two regions. The affordability factor and what is so important in making these units, bringing the costs down of the unit, is also to hopefully attract an affordable private pay

population, people who won't qualify for Medicaid because they have too many assets. Although their income may not be that high. Or people who may have a pension, but their pension isn't very high. Or people who were just never paid that much for assisted living but would want to pay that price. That's very critical that the cost of housing be affordable so they can hire people to provide the services. The services are costly to provide because it involves labor. One of the sustainability things we are very excited about is we are going to be developing a resource guide for interested providers. There will also be a website directory or guide that will be available to provide information to consumers as well as interested developers. They will be able to download parts of it or all of it and we will have it in paper form because this is a very complicated process. The housing finance or the loan from having tax credit is complicated as well as unique with financing because no federal funding sources will provide all the financing. So it is a very complicated process. We want to be able to provide as much information and guidance to interested providers as we can. I think that's all the comments I have but I will be happy to answer any questions.

ROGER AUERBACH: Looks like no questions for Alison.

TAMMY LEBLANC: Okay. No questions for Alison. The next part will be update from money follows the person. A little bit background on money follows the person. It is part of the rebalancing demonstration act to states. It's to help people who are in nursing home facilities or developmental centers who want to live in the community and can live in the community to actually have the opportunity to move into the community. As CMS realized, it actually takes more staff do that. They give an enhanced match for the first year for people as they are in home and community based waivers. That's the incentive to the states for doing it. Of course the incentive overall is that the people who are living in these facilities who really want to be in the community living their lives have the opportunity. That's really the bottom line. Today we have Faimon Roberts from office for citizens with developmental disabilities who will go first and give an update where they are. Following him will be Celeste Henle who is on the OAAS side. Go ahead Faimon.

SPEAKER: Thank you. I think the reason Tammy did not put Celeste and I on the agenda is she heard I had

48 slides for this and Celeste had 80. There are 3 other important parts to me who is standing here, Amy Bamburg who is my director and works with this in conjunction with Alison wrote this part of the grant and got it funded. I would also like to introduce you to Heather roar and Chris tip ton who is transition quality and management coordinators in our office for this program. The MFP rebalancing demonstration, we couldn't find anybody who wanted to be either rebalanced or demonstrated. So we call it my place Louisiana. It was originally my place. But somebody wanted to know if they could go to Arkansas. So we made it my place Louisiana. We are in phase 1 right now. We had a huge program and CMS pushed us back to certain levels. Phase 1 is waivers we already have funded and approved. In the office for citizens with developmental disabilities, OCDD, we have one waiver that's to move children out of nursing facilities. When we started there were 12 children in nursing facilities. We have actually moved one out of a nursing facility. We have 3 others who have signed informed consent. We are in the process of getting ready to move them hopefully. The other thing is in phase 2 we have been waiting on the residential options waiver. As you heard

Kathy said this morning it has been approved as of September 30. So we are in the process of getting all the necessary rule banking accomplished and getting other things done to get that ready. We will do 3 things with row in phase 2. We will continue to move children out of nursing facilities. Sometimes Children's Choice is not enough of a waiver to move. But the row can be used. We will also be doing conversions of group homes to row waiver homes. We will be going back to the registry and starting to move down and look for people who are in ICFs, particularly the private ICFs, to give them an opportunity to move to the community. Another couple things I would like to say is that we will be having a coordinating committee meeting. That's 24 people on that group. This is a stakeholder group that is used to inform us about what we are doing and how we could do it better or how we could enhance it or how we could reach people. We'll be having the first of those in January. If you would like to participate in that, please contact any one of us whether it is on the O F side or on the OCDD side. Also as far as housing, housing is a huge issue in this. Our one person that moved received, when we got linked to support coordination, they found public supportive housing for us. We had a

house for this young man. He was going to move there. The problem was that he didn't move for 2 months, and he didn't pay. He was in a nursing facility. He couldn't pay either his deposit or his first month's rent. So the housing was taken back. Once we established a date and knew when he was going to move, we asked the regional office. They paid the deposit and first month's rent. We went little bit further down the road. We ran past all that. The regional office paid for the second and third month's rent. Then we were actually able to move him. Also the Louisiana DD council, we had received funding from them, a grant. We used $1000 of their money because this kid had a Children's Choice waiver. He had nothing for building. That paid for furnishing and towels and all those things. So that was a big help. Housing, I can't tell you how big an issue with the 3 people we are talking to now. Two of them are stuck on housing. And we will move on. I can say that the 3 of us and Amy work on this project. No, everybody in OCDD gets a piece of this. They get lots of work to do. They have been great support to us. That's keeping it under 5 minutes. I will be glad to answer any questions. I will be glad to stay around afterwards and talk to you about it in any way, shape, or form. We are in OCDD.

Hearing no questions.

SPEAKER: I will try to talk and not be repetitive as to what Hugh said earlier today as to programs we administer and implement and Faimon and what's going on with -- I am Celeste Henle. Rachell is my transition manager. She helps me manage transitions we are getting. We are a little late started than OCDD but I am proud to say we are piloting region 1 with the office of state -- when they go into the facility every 30 days they do a self assessment and ask people who are interested in moving out, having them sign a self interest form, forwarding it to us. We are going out, Rachell and I in a lot of instances, and going into the facilities and handling the EDA waiver opportunity to move out. I wish it was as easy as them saying yes I want to move out and signing. Unfortunately the majority of them, probably 65 percent, need housing to move out. Probably out of the 65 percent who need housing, 62 percent need documentation to apply for housing which is a barrier in itself because a birth certificate costs $15 and a picture ID costs 12.50. These are barriers we are working as a team to overcome. So far we have received, it changes on a daily basis. It was 116 two days ago. I think we are up to about 121 now of informed consents, people

that have signed saying they want out. We have a couple closures, a couple that have died. I think that total is around 16. We have successfully transitioned 8. It will be 8 as of tomorrow. So far we have gotten 10 applications completed and submitted to H A N O who is working in conjunction with us. I think Alison had started with that, her and Amy, when they were writing money follows the person to have a working relationship with H A N O to be willing to set aside housing vouchers. Eve et job is the housing coordinator and is working on the MFP team. She is absent today due to illness. She has really put forth effort too in getting applications filled out, going to nursing facilities. There is a lack of transportation. They can't come to us so we have go to them. Fill out applications and then us coming up with different ways that we can maneuver through the system to get the documentation that is needed to apply for housing. So that's some of the things we are working on. So successfully we have transitioned 8 people. Successively we have received 121 informed consents. The challenges again is housing. Along with Faimon I am inviting y'all to please, if you have invested interest in people getting out of nursing facilities that want to get out, housing is a huge bridge that we need

to have built to housing. So please come and join in our stakeholder meeting that we are trying to prepare for and hold, we are looking at the later part of January. One more thing Faimon didn't touch on. There is a quality of life component. People in my place Louisiana. A lot of people say what's the difference? If you are in a nursing facility right now, you could contact us, Office of Aging and Adult Services, and say I would like to move out and you get a priority EDA waiver slot. So they can say I don't want do my place Louisiana. With my place Louisiana there is a quality of life survey. There is 3 done. One prior to transition, one 11 months after transition, then one 24 months after you have transitioned that you have been home. So CMS is collecting that data. Hopefully they're going to utilize that data to see the satisfaction of institutionalized care verses being in your home and hopefully will open up more avenues and more chances to have home and community based services in the future. That's another positive with this. Questions?

AUDIENCE: From the elderly, aging population standpoint, I know you mentioned you had grants to assist with getting furniture, towels, the whole gamut of things they would need to transition from a nursing

facility into their own home. I mean, I congratulate you on the success and it sounds like something I want do. But what's the sustainability? It seems like everybody is involved with the sustainability of multiple people. For yourselves, is there funding for that? If we took on that task, is there financial support for us to support our people.

SPEAKER: Before funding for money follows the person was handed down, we were going into nursing facilities and identifying those folks. They're on the registry, interested in moving out. They come up. We go out and offer them a waiver slot. The problem is we are having a lot of training that needs to be done with our support coordinators to enhance their ability to exactly recognize and to build within the community supports that are needed. I know for your agency there is not any grants that are going to provide us furniture or food to stock. It's going to have to be some creative work on the support coordinator's side. It can be done. I was a case manager for 10 years. It can be done. There is a lot of people out there who want to donate, who want to help. There are churches, Lion's Clubs, Civic organizations in the community whose sole purpose is to help. It is a manner of connecting with

your community when you are service support coordinator. Find out who can help. Attend the meetings. It is more than paperwork. It can be done. We have within our waiver on the OS side a $1500 transition fund they can use which would help set up some of the furniture and stuff. It's funny because Rachell and I were out in New Orleans one time. We went to lunch and passed by this huge Salvation Army home store. We go in to see if they have furniture. There are table sets for like $199. Nice, nice couches. We were shocked. She found the manager and he said we don't always do deliveries but if a nonprofit contact us and we know it is for homeless or they're trying to set someone for housing, we will deliver. There are avenues for venues. Sometimes you just have to ask the right questions.

ALLISON VULJOIN: Region 11 New Orleans for those that didn't know. When Celeste was talking about the cost of birth certificates and ID. Nursing home residents, they only get to keep $38. Region 1. When you are talking about cost for birth certificates and picture IDs they have to save for like 2 or 3 months to be able to apply these things. The grant we receive, it gives additional Medicaid match and then it gave admin

funds for specific things we can use. Didn't give admin funds. We can do 50/50 match which is the same match we get. We didn't get a pot of money we can use to buy things. We have a budget for what we can use money for, but we didn't get additional money in this grant. -- housing authority of New Orleans.

SPEAKER: In the row grant you get $3,000 of transition funds that moves a person from the ICF or the nursing facility over into their own. We did get some funding originally from the DD council that allowed us to add some extra support.

ALLISON VULJOIN: Right. If you are in a waiver there may be services that can be used. But from the money follows the person grant there wasn't a pot of money we could use for various services that people might need to transition. When Celeste talks about barriers, I think that's what we are talking about. Not only if you are in the service can we use the transition monies to buy certain items. Only if you are in that service. Unless you get a pot of money from another organization to use for certain services.

SPEAKER: I will even go further. You are lucky if you get $38. That's if you have actually paid in and you actually get -- that's the max. We have people who the

most they get is $8 because Medicaid is funding or paying the majority of their stay for nursing facility care. The most they get is $8. It takes a lot of months to save up on $8 a month to get a $15 birth certificate and 12.50 picture ID. Those are barriers we are working against. Any questions?

TAMMY LEBLANC: Thank you so much. Thank you for not using your 45 slides and your 80 something slides.

SPEAKER: Mine's only 10.

TAMMY LEBLANC: Roger, you want to add something.

ROGER AUERBACH: I was wondering. I think he said she said 80.

SPEAKER: She's hiding them.

SPEAKER: I haven't got out with the digital camera yet. He has pictures of people moving.

TAMMY LEBLANC: For the final event of the day I would like to introduce Donna Thompson. She has been working with consumers and stakeholders on the report I talked about, easy to use. If you will look in your folders, please pull out the report itself. There is a set of structured questions. Donna will give a report of the comments we have already gotten. Then when she is done we will move you around at the tables and have you read the report and in the group talk about how

useable or if you have any comments or input for us. Then we'll have a short report from each table.

DONNA THOMPSON: Hi. For those who know me hello. Then for those who only know me as being in the background, this is the face to the E-mails and all the phone calls you get with the systems transformation grant. I have an undergrad degree in journalism. One of my passions is making sure that the consumers understand what we put out. In one of our quality meetings they were discussing different reports we put out about healthcare reform and things. I thought we need to concentrate on what the consumer is reading and whether or not that consumer will be able to understand. I mean, we understand it because we do it everyday and it is our jobs. But for them to sit and read the report, sometimes it can be a task. In journalism we were taught always write for 4th grade level. I still hold true to that. So what I did was with the people, some great people through two organizations, people first of Louisiana and Families Helping Families. I get together with them. You will see this in your packet. Oh, I am sorry. This is the report. It is the health indicators report. And along with the health indicators report was a fax sheet. I sent that over to these people. I asked

them since they deal with the community, would you please disseminate this and have them read it. I gave them a week, week and a half to read it. And then give me feedback. I came up with probing questions. They were free to say anything they wanted to say about the report. But I thought the questions would help them out to see where we were going with this. I got some interesting results from that. I will not read all of them, but I will touch bases on a few of them. I thought it was really important that we get the consumers' voice and not just someone who has a college education to be able to read this report. I wanted to see who else would be able to read a report. One of the questions, was the report easy to read? For the most part -- sorry. There were 15 participants in all. I forgot to put that on the sheet. Forgive me. But everybody said yes, it was easy to read. One person did mention that the read ability level was too high and should be lower for consumers with literacy challenges to read. You see, that was something that really is my goal, to make sure that that is understood when we write these reports, that people need to be able to read them and not throw them to the side because they're too difficult to read. Second question was is the information easy to understand? 13

out of the 15 said yes. Two said no. One thing that stood out with me was someone mentioned it should translate more of the writing into graphics. I guess, when we are in school, you learn some people learn differently. Some people see things. They need a graph for it. We have graphs, but the graphs need to be easily understood as well in our report. Did you have difficulty understanding the graphics? Most of them said no. One that stood out with me is it is the most catchy portion of the document. Background for creating health indicators report and key page was excellent. That was this fact sheet that they were mentioning. Sometimes you just need a little help and having a fact sheet or something shorter than the whole report to give them a background and get them comfortable with the report. So when they sit down and read the report, they at least know what they are getting into. Did you find the information useful and please explain? Most of them did find the information pretty useful. There were the few comments that came to mind. For someone in the healthcare field, yes. But for me personally, no. Of course I don't know who this person was, but that's letting me know that there was something slightly off about the report that's throwing them off. It was

interesting finding out what's going on in our state. That's what we are trying to do. We are trying to give them the information to let them know what's going on in our state. The report is useful for education, quality assurance, transparency and caring. That's exactly what we are trying to do. We are trying to make sure that we can use these reports to educate for quality assurance, for transparency purposes and for the caring of our clients. Good to see that this is being looked into. I find a lot of those answers came back, that they didn't think we were even doing any kind of research or any kind of background things on what this report brought forth to them. The 5th question was did you feel as if the report was too long? We know that sometimes if we get a report that's 50 pages long, we really are not going to read the entire report in its entirety. This report was 21 pages long. I thought it was short enough for them to handle. A person said a study on healthcare was to be thorough and factual so the length was great. Another person said too long but executive summary and key findings section gives shorter overview for those who won't want to read the whole document. Again, this little fact sheet, it helped. Sometimes we may not put the entire report out everywhere but we may have the little

fact sheet out to get you interested in what the report is going to get into. What do you suggest would be the best method for distributing this type of information? Really this is the key of what I really am interested in as well. How are we going to get this information out? How is the general public, our consumers, self advocates, our organizations we deal with, how would they like to get this report? One of our participants hit the nail on the head when they said who needs to read it. That is what we need to focus on. Who is going to read this report and then that's how we'll know how to disseminate it. So a few things that came up were of course E-mail or mail to the participants that's receiving services. Pamphlets, news letters, public awareness campaigns. Even media with service announcements on TV and that sort of thing. For a report I don't know if that would be appropriate but I like to get these ideas out. At least we can play with the ideas to know what the consumers want. I asked about any additional comments. Pretty much everybody was thanking us for putting this report out because they were not aware of what's in the report or just to know that we are working on it. I was very clear that it was a draft. So just the idea that we are working on this information, that puts

their minds at ease. But I found that the most important thing, which was right there with me, it was the last one. It says table 3 has a justification issue with the word dehydration. In the 2007 titles of the graph and N on the word, was not on the same line. For me, proofreading. That's the big deal. We even want those types of responses, even if it's down to proofreading. We want this to be readable. We want it to be concise. We want it to be something that they can easily understand. For the most part, if anybody has any questions about this little project. It was really impromptu, wasn't anything that was broad. It was just something that came up in a meeting, and I figured to get a consumer's voice if I could just get together with a couple of our organizations that we deal with and get the consumers themselves or their family members or somebody to just voice what they want instead of us just always kind of thinking for them. I wanted to hear what they had to say.

AUDIENCE: I am assuming that the final version will be on the O A A.

DONNA THOMPSON: She asked whether or not the final version will be put on the website. I was letting her know once we have the final version, yes, all our reports will be placed on the website.

ALLISON VULJOIN: On the systems transformation grant page.
DONNA THOMPSON: Yes. For anything, like this meeting and past meetings, the transcripts are on the website now. Like this one, it will be on the website tomorrow or within a week or so. But everything is placed on our website.
AUDIENCE: I was one with Families Helping Families that did the survey and read it. We all discussed it. I thought it was great and we were very proud to have the input with it.
DONNA THOMPSON: I really appreciate that. Thank you very much.
ROGER AUERBACH: Any other questions for Donna on the survey or results?
TAMMY LEBLANC: Thank you very much. I like her focus on the consumers. She just stays true to that. I did want to ask before we give you a chance to read it and give us input, are there any other organizations here that feel like if their consumers, membership or whatever would read it they could give us this kind of structured information? Just checking. We wouldn't mind this being as broad based as possible as we get the input. What we wanted to do now is just to give you

a chance at your table -- soft tables are getting a little bit not too many people at them. This whole group here may want to kind of get together at one table to give you a chance to read the report and then each table maybe give us some input as to what you think about it. If you work with a certain population, kind of read it with their eyes so you can tell us what if anything we can do better.

TAMMY LEBLANC: Seems like everybody read the reports and are ready to comment. We will start with the loudest table over here to my left. They're the loudest. I'm glad someone's awake. If y'all would give your attention.

AUDIENCE: We really enjoyed this exercise. Thank you very much for this. Was the report easy to read? First of all, we took this directly from the standpoint of the consumers that we serve. One of the examples at our table was you cannot call during the day time to one of these people and expect to get clear concise information. So our take was while it was easy for us to read because we have the knowledge of it, we are a little more educated than some of the average consumers we serve, it is not easy to read. Some of the language in here, I know I would have to clarify for some

of our participants. You can run the gamut of some of the stuff. But having to bring it a little bit further on the level that it's easy to read. Also I think the font. This is from my standpoint the font is overwhelming. I think it is too small. They want something that jumps out at them that gives direct information. I hate to say this but they don't want to take the time to really get all that's there. So if the font was a little bit bigger, then it would grab, key words would jump out to them immediately. They would see longterm care, making it better. It would jump out immediate. Was it easy to understand? Yes. Did you have any difficulty understanding graphics? Charts and possible focus on specific -- say if I am in an ICF program, you would highlight ICF program in relation to the whole. Or something glaring out that was more specific to them. If you look at it and you say some 0. You can see it is 0. My group has 0. They wouldn't change, okay, whatever. If it was more relate able to me specifically.

TAMMY LEBLANC: Did you get a couple of the comments.

DONNA THOMPSON: A person was like this may be more adaptable to somebody else but not for me personally.

AUDIENCE: Right. If it was more focused to them specifically. If I move to the next thing, was the information useful, again, this is me standing in the place of some of the people we serve, my comment or our comments were if I received one of these, why do I care about the information that's in this packet? Tell me why this is important to me. I think that would have been more relevant. Tell me why it is important. Why should I care? Even if you say okay, there is a high instance of bacterial pneumonia. Well, this is what you can do from your standpoint. You can work with the states to help serve better, something relational to them. Unfortunately we have the sense of entitlement and we have the sense of I, I, me, me. More of a focus on them to get them to buy in to help us help them. Did I feel it was too long? Yes, I did feel it was too long. Imagine again the consumer you are serving in the executive summary and they have already zoned out because it is too wordy. I think the one pager was much more effective and maybe a chart in there, maybe a little bit more color, something more enticing, a little bit more enticing and getting directly to the point. The best method, you couldn't have said it better Donna, who is it going to? That's where it is going. I think the mail outs

aren't successful sometimes because as we mentioned, they get stuff and if you have to spend time and call them so they'll get something or they're calling you trying to figure out what it is. Maybe if it is something like somebody goes into their home, like a caregiver or somebody goes in and tells them what's going on. Oh, look we got this. But the mail out is kind of difficult because on the agency standpoint we are spending a lot of time calling and explaining it to them or receiving calls and explaining it to them. Additional comments. I think at the end of the report the group should report on private instead of current. If we are talking about bacterial pneumonia, what is the state doing to correct bacteria pneumonia? What are they doing for improvements along. Tell them about the housing, tell them about initiatives going on. I think some of the problem is people don't have a clue or they don't really know. One of the people at my table said it was coming up, they had been on a waiting list for a long time. Then when you went to give them information, they were totally oblivious. It's like I have been spending all this time. I really don't care. So more updates on projects coming up so they can be on the look out. Oh, it is coming up. When you hear about it, it will bring more

awareness. They will tune in more if they know what's coming up.

ROGER AUERBACH: Where do you want to go next, Tammy? Back table.

AUDIENCE: Basically we thought it was a little too long for consumers. Some of the comments from the other table we agree with. We agree with a lot of what she said.

AUDIENCE: Have you thought about putting it like in a DVD. My great aunt asked the other day. She was on the phone with Humana and she said if you got a DVD, I can see it. She would rather that. And they are sending her a DVD of her benefits.

AUDIENCE: I would have the Louisiana healthcare review look at this. They look at hospitalizations, and they're doing work in longterm care. They're in two other states. So they may look at this and give you some other critical information you might be interested in.

ROGER AUERBACH: No talking at this table. Everybody did individual work. What do you think about that? I don't know if it's the people giving the instruction or the people receiving. You did talk. Anybody want to share any insights as individuals if not as a group.

AUDIENCE: I want to say what she said is awesome and she needs to be on the team with all this because that was great.

JULIE NESBIT: I am really not clear on who this report is for. Originally I thought it was supposed to be for the consumer. But when I read this, I don't know any consumers that, number 1, would be interested in everything that's in here and secondly, that would understand how it relates to them. It's good information, but it's like so what does it have do with me? I think we need to decide who the audience is before we can decide the format and the content.

AUDIENCE: I will be honest. I didn't get a chance to read it because I need quiet when I read. It was so noisy in here. One of the things I did notice is in the probing questions. If I understand correctly, they were sent out with the report. Number 5 is a leading question. So we have to be careful about how we word questions when we are probing. It says something about how you feel. You don't want to do that when you are questioning about things. So I feel like that shouldn't be worded like that.

AUDIENCE: Joe Hicks with the office of aging. I am biased because this is the kind of report I like, because

I've always looking for information as a government employee. I am looking for information, numbers. So I understand that this report wouldn't help legislators or consumers or a lot of people in between. So for me, this report I guess is trying to do too many things. It is trying to be for the consumer and the researcher. I think maybe have a very specific report for the researchers and another report for the consumers. I would think about a brochure or news letter, especially in the office of aging. It's the betweeners looking for the information. Daughters trying to take care of grandma and they're in New York or California and they're looking at this at 2:00 in the morning after they put kids to bed and they need stuff that jumps out about what's the best program or facility to put mom in. They need report cards and information that is digested already for them. We choose our audience. Then choose the message and the medium.

ROGER AUERBACH: Anybody else at this table?

AUDIENCE: We basically have just one additional thing to add. Everybody's already reported out the really valuable information. One thing I did notice was that it seems to be recording. It seems to be a report on a specific population and a specific group of services

that's kind of presented as if it were a larger population, larger group of services. For example, it refers to Louisiana's longterm care agencies which are OAAS and OCDD. But those aren't the only two. There are other Louisiana agencies, state government agencies, that provide longterm care services. But it's like they're not mentioned. These two agencies provide all the services. That put me off a little.

ROGER AUERBACH: Last but never least.

DENA VOGEL: We like this short bulleted part. What we would suggest is the one page here, at the bottom this is what you might want to give to people getting services in families. Then at the very bottom that you let them know that there is a report with more detailed information and a website that they can obtain it on or a name and a phone number that they can call in order to have a long report sent to them. Some people would look at it and say I want more information and it will be available to them. For some people this will be enough information. I, like Joe, liked the detail in this as a quality specialist. I want to know the numbers. I want to see exactly how the comparisons between services and things like that. So for some audiences, you need this information. When we presented this, when Mandy

presented this to our performance review committee within OCDD which is the programmatic administrative staff, they even wanted more detailed information, even more than was in here. So we contacted and said where did the national statistics come from? What was this? What was that? In fact we wanted even more than this. As far as distribution goes, we had thought of some places to distribute this. Many of the Families Helping Families organizations do a news letter I think quarterly or something like that. This little thing here, not the big long report, but something like this I think they would be willing to include in their news letter. Then with that, if you want the full report, this is how you can obtain it. Also other places to distribute would be the DD council, the Advocacy Center, and the centers of excellence that used to be --

AUDIENCE: Health Sciences Center.

DENA VOGEL: Right. They have a thing called triad where they work together.

AUDIENCE: Triangle.

DENA VOGEL: They have a news letter they might want to send this on. Also distribute the information to some of the various stakeholder groups such as provider groups, case management alliance, AARP,

those kind of groups might have that available for people. As well, this little one sheet handout, everybody in community services who have a waiver services have a support coordinator that goes out there. We could have them give this to the person during their annual planning visit and again if they want more information it tells them how to obtain it. The people who are in ICF/DDs and nursing homes there are programs that can help distribute this information to the residents in those facilities to get the information. I think there are a lot of avenues we can use to get the information out. Is there anything I missed here?

TAMMY LEBLANC: A loot of brain power for this late in the afternoon. I am speaking for everybody.

ROGER AUERBACH: One more comment.

AUDIENCE: To piggyback on the DVD idea, consider other mixed media, like even audio. People listen to audio books or iTunes. That might be another avenue.

AUDIENCE: It probably was good for us to -- wasn't good for us to get this in the afternoon because our attention span was shorter.

TAMMY LEBLANC: Personally I want to thank everybody. It has been a great day. I know there is a lot of information given out and a lot asked of you to

actually give us this input. The next meeting will be in July. We don't know when except we know it will not be the third week in July because that's when the DD council has their meeting. So we'll let you know ahead of time. It will be our lasts meeting. So we'll make it extra special for that reason. I do want to let Roger make a few comments. You have an evaluation in your packet. You can drop it off by the lunch boxes as you pick one up and two cookies as you go out the door. Roger, you have any comments? You want to wrap it up?

ROGER AUERBACH: We'll wrap it up. I want to say thank you again to everybody for coming and for staying. Especially those who are here now. Thank you so much for staying for the whole day. Again, we appreciate very much your feedback, especially in this last piece because it is very important for us to be able to -- now that we have been able to capture -- first of all to be able to adopt quality measures across a lot of populations, to be able to have consumers actually have access to the data, to be able to give further feedback on quality, on achieving out comes is very, very important and something we'll need to do as we try to sustain the momentum of what we have been doing now

with this grant for many years. Again, please spread the word for July. I know it is just a few months away. The weather will be different. It won't be rainy outside. It will be our last time together as a stakeholder group as the grant will end on September 30. So we will be focusing again on sustainability. We will be doing a bit of celebration as we reflect on the achievements of this grant. From a national perspective and again for people who don't know me as well, I spend my life going to different states working with state Medicaid agencies to state disability and aging agencies all working on systems transformation in one sort or another. I would like to always say to this group that you really should be proud of the work that you have done with systems transformation grant specifically and on your work at making this system really person centered, focusing on outcomes, focusing on choice and empowerment for individuals. You have achieved a lot. I have been able to look as an outsider to be able to benchmark that achievement. I am happy to be working now in a state that is 49th out of 50 in terms of supporting people with home and community based services. I like to say to them look at Louisiana, look where they were 5 years ago. Look where they are today. So you are in fact a

model for a number of states and a positive model. So let's remember this as we all go through tough times, budget times. Everybody across the country, almost every state I work with -- every state I work with is going through hard budget times. So again keep focus on the things that you have adopted as your goals and this economy will turn around. Budgets will get better. We all have to be prepared for the good times as they come and be ready to keep on moving forward with the goals and objectives that we have. Again, thank you all very much. Have a safe trip home and have a wonderful holiday season.